

PERCEPTIONS OF MENTAL ILLNESS IN SOUTH-EASTERN NIGERIA: CAUSAL BELIEFS, ATTITUDES, HELP-SEEKING PATHWAYS AND PERCEIVED BARRIERS TO HELP-SEEKING

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Abstract

To provide empirical basis for mental health interventions in the deprived sub-Saharan African region, this study explored the perspectives of the Igbo people of south-eastern Nigeria on four dimensions of mental illness: causal beliefs, attitudes towards sufferers, preferred treatment pathways and perceived barriers to accessing formal psychiatric care. Mixed sampling methods were used to select participants who completed quantitative questionnaires. The number of participants varied between 200 and 706 in the exploratory studies but remained constant ($n = 1127$) in the confirmatory studies. The study found mixed endorsements of the supernatural, biological and psychosocial causal explanations with supernatural causations being significantly more endorsed. The study also found mixed treatment preferences with formal psychiatric care being significantly more preferred to the spiritual pathway which was in turn significantly more preferred to the traditional pathway. Significant negative attitudes and desire for social distance from persons with mental illness were observed across groups. Barriers to accessing mental healthcare were also significantly perceived with ideological barriers being significantly more perceived than instrumental barriers. Systematic associations were found between causal beliefs and treatment preferences: supernatural causal belief predicted preference for the spiritual and traditional treatment pathways while psychosocial causal belief predicted preference for both formal psychiatric care and the traditional treatment pathway. Mixed causal attributions and treatment preferences reflect holistic view of health and healing and calls for the evolution of complementary model of care that would incorporate people's spiritual and cultural needs. The prospect is supported in psychosocial causal beliefs being associated with preference for the traditional treatment pathway. Significant negative attitude is a contradiction in the traditionally communitarian and predominantly Christian culture, and is deserving of intervention in the context where the solidarity of the social network should compensate for the inadequate mental healthcare. Significantly more ideological than instrumental barriers have crucial policy implication; improved conceptualizations of mental illness should precede improvement of facilities and services or else these could be underused. Demographic correlates of causal beliefs, negative attitudes, pathway preferences and barriers to accessing formal mental healthcare care were determined for targeted interventions.

Table of Contents

1. Abstract	ii.
2. Table of Contents	iii.
3. Introduction	1.
4. Chapter One (Study 1)	
Causal Attribution for Mental Illness.....	6.
1.1. Introduction.....	6.
1.1.1. Theoretical Framework.....	6.
1.1.2. Causal Attributions of Mental Illness across Cultures.....	6.
1.1.3. Rationale for Study and aims.....	14.
1.2. Methods.....	16.
1.2.1. Participants and Sampling Technique.....	16.
1.2.2. Instruments.....	18.
1.2.3. Data Collection.....	21.
1.2.4. Data Analysis.....	22.
1.2.5. Ethical Considerations.....	23.
1.3. Results.....	23.
1.3.1. Exploratory Study (1a).....	23.
1.3.2. Confirmatory Study (1b)	28.
1.4. Discussion.....	38.
1.4.1. Conclusion.....	49.
5. Chapter Two (Study 2)	
Attitudes towards (Persons with) Mental Illness.....	52.
2.1 Introduction.....	52.
2.1.1. Theoretical Framework.....	52.
2.1.2. Stigma Typologies.....	56.
2.1.2.1. Public Stigma.....	56.
2.1.2.2. Self-stigma.....	57.
2.1.2.3. Associative Stigma.....	59.
2.1.3. Stigma Causal Factors.....	61.
2.1.3.1. Culture.....	62.
2.1.3.2. Nature and Symptom Presentation of Illness.....	63.
2.1.3.3. Diagnosis of Mental Illness/Psychiatric Hospitalisation.....	64.
2.1.3.4. Causal Explanation for Mental Illness.....	65.
2.1.3.5. Media (Mis)representation of Mental Illness.....	66.
2.1.3.6. Negative Policies.....	69.
2.1.4. Consequences of Negative Attitudes toward Mental Illness.....	69.
2.1.4.1. Social Exclusion.....	69.
2.1.4.2. Structural Discrimination.....	72.
2.1.4.3. Burden of disease.....	74.
2.1.4.4. Impeding Help-seeking.....	76.
2.1.4.5. Impeding Recovery.....	78.
2.1.5. Pervasiveness of Stigma.....	80.
2.1.6. Rationale for study and aims.....	84.
2.2. Methods.....	86.
2.2.1. Participants and Sampling Technique.....	86.
2.2.2. Instruments.....	86.
2.2.3. Data Collection.....	89.
2.2.4. Data analysis.....	89.
2.3. Results.....	89.
2.3.1. Study 2a (Attitudes towards persons with mental illness).....	89.

2.3.2. Study 2b (Principal Component Analysis of the Social Distance Scale).....	92.
2.3.3. Study 2c (Exploratory study on Social Distance desired from people with mental illness).....	93.
2.3.4. Study 2d (Confirmatory study on Social Distance desired from people with mental illness).....	95.
2.4. Discussion.....	98.
2.4.1. Conclusion.....	108.
6. Chapter Three (Study 3)	
Preferred Pathways to mental healthcare.....	121.
3.1. Introduction.....	121.
3.1.1. Theoretical Framework.....	121.
3.1.2. Pathway Typologies.....	121.
3.1.2.1. Mainstream (Psychiatric) Pathway.....	121.
3.1.2.2. General Medical Pathway.....	122.
3.1.2.3. The 'Free Market' Model.....	122.
3.1.2.3.1. Spiritual Pathway (Faith Healers).....	125.
3.1.2.3.2. Traditional Pathway.....	126.
3.1.2.3.2.1. The social network.....	127.
3.1.3. Rationale for study.....	131.
3.2. Methods.....	133.
3.2.1. Participants and Sampling Technique.....	133.
3.2.2. Instrument.....	133.
3.2.3. Data Collection.....	134.
3.2.4. Data Analysis.....	134.
3.3. Results.....	134.
3.3.1. Study 3a (Principal Component Analysis).....	134.
3.3.2. Study 3b (Exploratory Study).....	136.
3.3.3. Study 3c (Confirmatory Study).....	139.
3.4. Discussion.....	143.
3.4.1. Conclusion.....	155.
7. Chapter Four (Study 4) Barriers to Mental Healthcare.....	157.
4.1. Introduction.....	157.
4.1.2. Help-seeking Determinants.....	158.
4.1.2.1. The Socio-cultural Context.....	158.
4.1.2.2. The Conceptualisation of Disease.....	159.
4.1.2.3. Cultural (in)appropriateness of care.....	163.
4.1.2.4. Culture of self-reliance.....	168.
4.1.2.5. The Social Network.....	169.
4.1.2.6. Stigma of Mental Illness.....	171.
4.1.2.7. Mental Health Literacy.....	171.
4.1.2.8. Accessibility of Care.....	172.
4.1.2.9. Experience of the Mental Health System.....	174.
4.1.3. Theoretical Framework/Rationale for study.....	180.
4.2. Methods.....	184.
4.2.1. Participants and Sampling Technique.....	184.
4.2.2. Instrument.....	184.
4.2.3. Data Collection.....	185.
4.2.4. Data Analysis.....	185.
4.3. Results.....	185.
4.3.1. Study 4a (Principal Component Analysis).....	185.
4.3.2. Study 4b (Exploratory Study).....	187.

4.3.3. Study 4c (Confirmatory Study).....	191.
4.4. Discussion.....	194.
4.4.1. Conclusion.....	220.
8. Chapter Five	
Relationships between Causal Beliefs, Attitudes, Preferred Treatment Pathways and Perceived Barriers to Help-seeking.....	224.
5.1. Relationships between the 4 perspectives on mental illness explored using Pearson product-moment correlation coefficient.....	224.
5.1.2. Summary of findings.....	224.
5.2. Regression procedures.....	225.
5.2.1. Summary of findings and preliminary discussion).....	226.
5.3. Discussion.....	226.
5.4. Summary of findings, Practical Implications and Recommendations.....	232.
5.4.1. Chapter One.....	232.
5.4.2. Chapter two.....	233.
5.4.3. Chapter Three.....	234.
5.4.4. Chapter Four	236.
5.4.5. Chapter Five.....	237.
5.5. Limitations of Study.....	238.
5.6. Conclusion with proposed direction moving forward	240.
9. References.....	243.
10. Appendixes.....	294.
1. Content Analysis of Qualitative Data	294
2. Tests of Mediation effects.....	302.
3. Causal Factors of Mental Illness Questionnaire (Adewuya & Makanjuola, 2008)....	307.
4. An adaptation of the Community Attitudes to Mental Illness scale (Taylor & Dear, 1981) and Social Distance Scale (Ikwuka et al., 2016a).....	308.
5. Help-seeking pathways scale (Ikwuka et al., in press) and Barriers to accessing conventional mental healthcare (Ikwuka et al., 2016b).....	312.
6. Combined scales for the confirmatory studies on causal beliefs, attitudes, help-seeking behaviour and barriers to helps-seeking for mental illness.....	315.
7. Questionnaires with Igbo translation.....	320.
8. Ethical Clearance Certificate from the Univeristy of Nigeria Teaching Hospital, Enugu.....	327.
Tables	
1. Chapter One (Study 1)	
1.1. Scale items for Exploratory Study on Causal Beliefs.....	19.
1.2. Scale items for Confirmatory Study on Causal Beliefs.....	20.
1.3. Socio-demographic Characteristics of the Exploratory Study Sample.....	23.
1.4. Descriptive Statistics for Causal Attributions of Mental Illness (Exploratory Study1a).....	23.
1.5. Logistic Regression predicting the likelihood of endorsing divine sanction.....	25.
1.6. Logistic Regression predicting the likelihood of endorsing fate.....	25.
1.7. Logistic Regression predicting the likelihood of endorsing supernatural causal model	26.
1.8. Logistic Regression predicting the likelihood of endorsing social factors.....	26.
1.9. Logistic Regression predicting the likelihood of endorsing personal factors.....	27.

1.10. Logistic Regression predicting the likelihood of endorsing psychosocial causal model.....	28.
1.11. Socio-demographic Characteristics of the Confirmatory Study Sample.....	28.
1.12 Descriptive Statistics for Causal Attributions of Mental Illness (Confirmatory Study 1b).....	30.
1.13. Logistic Regression predicting the likelihood of endorsing divine sanction.....	33.
1.14. Logistic Regression predicting the likelihood of endorsing evil forces.....	34.
1.15. Logistic Regression predicting the likelihood of endorsing fate.....	35.
1.16. Logistic Regression predicting the likelihood of endorsing supernatural causal model.....	35.
1.17. Logistic Regression predicting the likelihood of endorsing social factors.....	36.
1.18. Logistic Regression predicting the likelihood of endorsing personal factors.....	37.
1.19. Logistic Regression predicting the likelihood of endorsing psychosocial causal Model.....	38.
2. Chapter Two (Study 2)	
2.1. Socio-demographic Characteristics of Studies 2a and 2c.....	89.
2.2. Study 2a Association of Demographic Characteristics with Attitudinal Constructs of the Community Attitudes to Mental Illness (CAMI) scale.....	90.
2.3. Factor loadings for Social Distance Scale (SDS) (Study 2b)	93.
2.4. Exploratory Study (2c) Association of Demographic Characteristics with Social Distance Constructs.....	94.
2.5. Confirmatory Study (2d) Association of Demographic Characteristics with Social Distance Constructs.....	96.
3. Chapter Three (Study 3)	
3.1. Factor loadings for Preferred Pathway to Mental Healthcare scale.....	135.
3.2. Socio-demographic Characteristics of the Exploratory Study Sample.....	136.
3.3. Descriptive Statistics for Pathways to Mental Healthcare (Exploratory Study)	137.
3.4. Standard Multiple Regression of Demographic Variables as Predictors of Treatment Pathways (Exploratory Study).....	138.
3.5. Descriptive Statistics for Pathways to Mental Healthcare (Confirmatory Study).....	140.
3.6. Standard Multiple Regression of Demographic Variables as Predictors of Treatment Pathways (Confirmatory Study).....	142.
4. Chapter Four (Study 4)	
4.1. Factor loadings for the Barrier to Mental Healthcare scale.....	186.
4.2. Socio-demographic Characteristics of the Exploratory Study Sample.....	187.
4.3. Descriptive Statistics for Ideological vs. Instrumental Barriers to Help-seeking (Exploratory Study).....	189.
4.4. Standard Multiple Regression of Demographic Variables as Predictors of Barriers (Exploratory study).....	189.
4.5. Descriptive Statistics for Ideological vs. Instrumental Barriers to Help-seeking (Confirmatory study).....	191.
4.6. Standard Multiple Regression of Demographic Variables as Predictors of Barriers (Confirmatory study).....	193.
5. Relationships	
5.1. Pearson Product-moment Correlation between Causal Beliefs, Attitudes, Preferred Treatment Pathways and Perceived Barriers to Help-seeking.....	223.
5.2. Standard Multiple Regression of Causal beliefs as Predictors of Treatment Pathways.....	224.

Introduction

Mental Illness is a clinically significant psychological or behavioural disorder associated with distress, disability or a significantly increased risk of suffering pain, disability, death or important loss of freedom (American Psychiatric Association, 2005). Mental disorders are the leading cause of years lived with disability (YLDs) worldwide, accounting for 37% of all healthy life years lost through disease and 14% of the global burden of disease (Vos et al. 2012). They constitute risk factors for many health problems (Prince et al., 2007) and create substantial personal burden for affected individuals in terms of personal suffering, their families in terms of crippling burden of care and life-time lost productivity, and the society at large in terms of a drain on national resources (Foldemo, Gullberg, Ek & Bogren, 2005; Lopez et al., 2006). Epidemiological findings suggest that almost 50% of the population will experience at least one mental disorder in their lifetime, and at least 25% have suffered from a mental disorder during the past 12 months (Andrade et al., 2000). It is projected that common mental disorders will disable more people than complications arising from AIDS, heart disease, traffic accidents and wars combined by 2020 (Ngui et al., 2010).

Neuropsychiatric disorders contributed 4% of the disease conditions in Africa less than 2 decades ago (the burden of neuropsychiatric problems is relatively reduced in Africa due to the high burden of communicable, maternal, perinatal and nutrition-related diseases) but this is projected to rise to 18% by 2020 (World Health Organisation WHO, 2001a). Such disturbing trajectory notwithstanding, the mental health needs of people do not translate to seeking professional help. The majority of people meeting the criteria for mental disorders underutilize mental health services in spite of the availability of effective treatment for most mental disorders (Le Meyer et al., 2009; Burgess et al., 2009; Jagdeo et al., 2009). World Mental Health Survey (Wang et al., 2007) indicates that the treatment gap for severe mental disorders in Low and Middle Income Countries (LMIC) can be as large as 75%. The survey reported that persons with mental health needs receiving formal mental healthcare in Nigeria

over 12 months was as low as 1.6%.

Mental health is generally under-researched in Africa (Alem & Kebede, 2003; Gureje et al., 2005). This fundamentally undermines mental healthcare: policy initiatives, efforts at plugging the gaps in formal treatment, evolution of responsive models of mental healthcare and improvement of the notion of mental illness. To provide empirical basis for mental health interventions in the region, this study explores the perspectives of the Igbo people of south-eastern Nigeria on four dimensions of mental illness: causal beliefs, attitudes toward persons with mental illness, preferred treatment pathways and barriers to conventional psychiatric treatment.

The study focused on the Igbo people, east of the River Niger, a culturally homogenous people in five states of Nigeria: Anambra, Imo, Enugu, Abia and Ebonyi. The territory is located between latitude 5° - 7° north of the Equator and longitude 6° - 8° East Greenwich and covers approximately 41,604.2 square kilometres. The Igbo population is estimated at 30 million; approximately 18% of a total Nigerian 170 million population (The CIA World Factbook, 2012).

People's mental health reflects their socio-cultural context (Mulatu, 1999). Three major defining characteristics of the Igbo all have possible implications for their mental health. First is their widely acclaimed characteristic entrepreneurial spirit in Africa. More than half a century ago, Green (1947) had observed that the Igbo admire "the man of energy, the go-getter..." and that the qualities stressed in children's upbringing are property, money, honesty, and loyalty to kinsmen (p. 88). Corroborating this view, LeVine (1966) declared that the Igbo have the highest achievement motivation and are the most energetic parvenus of the three main ethnic groups in Nigeria. Through sheer grit and propensity for spotting new opportunities, the Igbo emerged as the dominant force in business in the region right from pre-independence Nigeria till present. Writing on the ingenuity of the Igbo, a social

commentator from a rival Nigerian culture (Ngulde, 2013) concedes that one hardly finds any group in the whole of the African continent more creative and more industrious. Yet, achievement motivated disposition usually goes with attendant stress and exhaustion which constitute risk factors for mental breakdown (Gilman, 1984; Rose, 2010).

Secondly, following their defeat to the rest of Nigeria in a battle for self-determination (1967 – 1970), the Igbo feel belonging to a persecuted minority (Achebe, 2012). Self-stigmatisation arising as a consequence of enduring impact of real or imagined discrimination and persecution could result in mental ill health (Schlosser, 2006; Kohn & Levav, 2000). Thirdly, the Igbo entrepreneurial spirit drives them to search for opportunities beyond frontiers hence their renowned migrant spirit which is succinctly captured in the native maxim ‘njepu amaka’ – migration is rewarding (Nwolisa & Eloka, 2003). On encountering the new culture, immigrants are usually faced with assimilation and acculturation processes more exerting than envisaged. First, they grapple with the sudden reality of losing their identity as members of a majority group to assume the status of a minority. Oftentimes too, immigrants’ cultural beliefs and practices are at variance with the mainstream culture. Thus, migration could involve significant cultural and psychological changes capable of triggering psychopathological reactions (Scott, 2002). This might explain why it is estimated that the prevalence of mental-health problems is up to 50% higher for people from ethnic communities (Minas, 1996). Yet, racial and ethnic minority groups are generally considered to be underserved by the mainstream mental healthcare system while many from the group feel ill at ease with the system (Scheffler & Miller, 1991; Takeuchi & Uehara, 1996).

Moreover, the foregoing subsists against the backdrop of developing countries experiencing significant socio-cultural flux: urbanization, migration, changes in family structure and supportive networks, increasing social and economic insecurity, widening social inequalities, and growing privatization of healthcare (Patel et. al., 2006). Some of these may not only be risk factors but could influence the course and outcome of mental illness. Furthermore, as

noted in *Bridging the Gaps* (WHO, 1995), the world's most ruthless killer and the greatest cause of suffering on earth is extreme poverty. While sub-Saharan Africa accounts for half of the global poor, Nigeria is identified as one of the five countries with the concentration of two-thirds of the world's extreme poor (The World Bank, 2014). Seventy-five percent of the population lives below poverty line, earning below \$1 per day (Ewhrudjakpor, 2010a).

Mental illness is conceptualised in the region mainly in terms of 'madness' - severe psychotic disorders (Igbinomwanhia, James & Omoaregba, 2013; Atilola & Olayiwola, 2011) with the common spectacle of the mentally ill being that of 'unkempt psychotic vagrant' (Ewhrudjakpor, 2010b). The research survey proceeded in this sense in answer to the following research questions:

1. To what extent do the Igbo people of south-eastern Nigeria make psychosocial, biological and supernatural causal attributions for mental illness?
2. To what degree do they demonstrate negative attitudes towards persons with mental illness and desire social distance from them?
3. To what extent do they seek spiritual, traditional and conventional psychiatric treatments for mental illness?
4. To what degree would ideological and instrumental barriers impede their help-seeking for mental illness?
5. In what ways do the four dimensions of causal beliefs, attitudes, help-seeking preferences and barriers correlate?

Each of the questions will be addressed in a chapter making the five chapters of the study. For each of the first four chapters, an exploratory study will precede a substantive confirmatory study. Chapters 2 - 4 will also involve the development of psychometric instruments to be deployed in their respective surveys. While the study is expected to add original knowledge to the fledgling literature in the region, it is hoped that the findings would inform policy initiatives in Nigeria and in societies with Nigerian and related ethnic minorities towards

plugging the gaps in formal treatment, evolution of responsive mental healthcare models, targeting of interventions and improvement of the notion of mental illness.

Chapter One (Study 1)

Causal Attribution for Mental Illness

1.1. Introduction

1.1.1. Theoretical Framework

Attribution theories explore ways in which people account for the causes of observed behaviour and the consequences of causal explanations. The processes may not be foolproof but they nonetheless serve the decisive purpose of granting people some sense of prediction and control over their lives (Fiske & Taylor, 1991). Heider (1958) identified two attributional processes: dispositional and situational. In the former, a person's action is attributed to internal dispositions such as attitudes, traits and motives while in the latter, a person's action is attributed to external or environmental factors such as socio-cultural, socio-economic and supernatural forces. Explanatory models of illness encompass a person's ideas about the nature of their condition: its cause, severity, prognosis and treatment preferences (Kleinman, 1980). Beliefs people hold about mental illness are influenced by ethnicity (Hall & Tucker, 1985), culture (Furnham & Chan, 2004; Jang, Kim, Hansen & Chiriboga, 2007), religion (Pfeifer, 1994) and socio-economic status (Dessoki & Hifnawy, 2009). Thus, people identify causal factors of illness that reflect the specific circumstances of their own lives.

1.1.2. Causal Attributions for Mental Illness across Cultures

Research indicates that contemporary Western (industrialized) societies primarily make biological and psychosocial (biopsychosocial) causal attributions for mental illness. These include genetic (Pillai, Kalmbach, & Ciesla, 2011; Shi, Gershon, & Liu, 2008) and non-genetic risk factors such as in utero insult e.g. illness or substance use and abuse during key developmental periods of pregnancy or obstetric complications (Matheson, Shepherd, Laurens, & Carr, 2011). These are indicators of vulnerability, which, impacted by environmental factors such as stress could trigger mental health conditions (Uher, 2013;

Rudnick & Lundberg, 2012).

National surveys of Germany conducted in 1990 and 2001 (Angermeyer & Matschinger, 2005) showed that psychosocial stress (including life events, stress at work, broken home) topped the public's causal attributions for mental illness. However, while lack of willpower was endorsed ahead of biological causations (brain disease and heredity) in the 1990 survey, this pattern was reversed in the 2001 survey. A cross-cultural study of adult population in Germany, Novosibirsk (Russia) and Ulaanbaatar (Mongolia) found that irrespective of respondents' different cultural backgrounds, their responses show similar trends with regard to attributing depression and schizophrenia to psychosocial causes with acute stress (life event) being the most frequently endorsed causation (Dietrich et al., 2004).

An 8-year longitudinal survey that examined changes in public beliefs about social and environmental variables as risk factors for mental disorders in Australia and Japan discovered an increase in the proportion of the public that made genetic causal attribution for both depression and schizophrenia (Jorm et al., 2005). The study speculated that the trend may have been informed by the awareness created by the genome projects. Jorm and Griffiths (2008) reported that "biochemical imbalance" is also a common explanation in Australia and the United States. A study by France, Lysaker and Robinson (2007) further linked the improvement of public awareness of biological causation in the United States to the introduction of Direct-to-Consumer (DTC) advertising in 1997 which allows pharmaceutical companies to market their products directly to consumers through media advertisements or promotional products. In particular, DTC advertisements for antidepressants often portray depression as a strictly biological disease that their products can treat. Ninety-one per cent of the participants in the study reported being familiar with the "chemical imbalance" theory of depression propagated by pharmaceutical companies.

On the other hand, it is believed that supernatural and religious explanations such as divine sanctions, evil forces and fate are mostly advanced in the non-Western (traditionalist) developing world (Idemudia, 2004; Kate, Grover, Kulhara & Nehra, 2012). A study that investigated the explanatory models for schizophrenia between Western (UK) and non-Western (Caribbean, Bangladeshi, West African) groups (McCabe & Priebe, 2004) found no differences between the three non-Western groups. However, there were consistent differences between the Western and non-Western groups. When biological causes were compared with supernatural causes, the Western group cited biological causations more frequently than the three non-Western groups that endorsed more supernatural causes. When biological causes were compared with social causes, the Western group cited biological causes more frequently than the non-Western group that conversely cited social causes more than their Western counterpart. When social causes were compared with supernatural causes, the Western group cited social causes more frequently than the non-Western group that were more likely to cite supernatural causes.

Similarly, using Sri Lanka as a case study, Furnham and Pereira (2008) investigated whether respondents from non-Western developing countries with supposedly more conservative, superstitious, morally and socially judgmental environments still hold folk and taboo notions of mental illness compared to the British population with supposedly more open health care system, mental health charities and campaigns for the rights of persons with mental illness. Their findings show that Sri Lankans of all educational levels hold more unconventional beliefs and demonstrate more negative attitudes towards schizophrenia compared with their British counterpart. They also favoured superstitious, family and sociological causal explanations while the British favoured biological explanations. In a comparative study of British and Chinese respondents, Furnham and Wong (2007) found that while the British mostly endorsed biological, psychological and sociological causal beliefs of mental illness and its treatments, the Chinese held more religious and superstitious views including beliefs

that mental illness can result from the breach of divine and ancestral taboos, predestined fate and evil done in previous life. The Chinese also favoured the use of alternative medicine. Bhui, Bhugra and Goldberg (2002) had similarly compared the causal beliefs of English and Punjabi respondents and found that while the Punjabis favoured more religious explanations, the English respondents endorsed more psychological explanations. The authors linked the more supernatural attributions of the Punjabis to their more traditional religious background. This supported the report that beliefs in magico-religious aetiology of both physical and psychological diseases are deep-rooted in the Indian sub-continent (Banerjee & Roy, 1998; Balhara & Yadav, 2012) and common in Asian cultures (Bal & Cochrane, 1993; Al-Issa, 2000).

A study that explored the causal belief for mental illness in a primary care setting in Saudi Arabia reported that patients attributed their symptoms to punishment from Allah (Alqahtani & Salmon, 2008). A related study of Arab-speaking people in Australia revealed the belief that the primary causal factors for mental illness are satanic powers, lack of faith, and the burden of sin (Youssef & Deane, 2006). Similarly, a study that assessed the opinions of 160 men in Yemen about the characteristics of mentally disabled people found that over 60% of participants agreed that a mentally disabled person is afflicted with an “evil soul” (Alzubaidi, Baluch & Moafi, 1995). Al-Krenawi (1999) also reported the endorsement of supernatural influences as causal factors for psychiatric illness by respondents in an Israeli study of out-patients who attributed their psychiatric illness to supernatural influences. Some Jewish respondents also believed that illness is a beneficial experience; a divinely presented opportunity for human reflection and soul searching to improve oneself and express regret (Selekman, 1998).

Mental illness is also viewed as a natural part of predestined suffering in other south-east Asian societies (Uba, 1992). For example, in the traditional Korean society, mental disorder was known as a crazy or divine disease which was treated by folk healers or Shamans

(Barcus, 1982; Nah, 1990). A study of pathways to psychiatric care in urban north China found a strong attribution of mental illness to evil spirits invading one's body or mental illness serving as a form of punishment for the wrongdoing of an individual or his ancestor (Phillips, Li, Stroup & Xin, 2000). The majority of families in Bali, Indonesia believed that schizophrenia is caused by supernatural agents such as witchcraft or evil forces (Kurihara, Kato, Reverger & Tirta, 2006). Earlier studies from rural areas of Turkey reported a high rate of endorsement of magico-religious causal beliefs by the psychiatric patients (Ozturk & Volcan, 1971). However, such beliefs appear to be waning with more recent studies reflecting mixed model of attributions with greater endorsement of natural and psychological causations (Minas et al., 2007; Tarskin et al., 2003). This is exemplified in the findings of an Indian study (Kate et al., 2012) that whilst two-thirds of patients with schizophrenia attributed their symptoms to supernatural factors such as sorcery, evil spirits, spirit intrusion, divine wrath, planetary/astrological influences and nemesis, more than two-thirds of them also attributed their symptoms to biological causes.

In spite of the cultural and ethnic diversity in Africa, there is a general belief that both physical and mental diseases originate from various external factors such as breach of a taboo or custom, disturbances in social relations, hostile ancestral spirits, spirit/demonic possession, evil machination, evil eye, sorcery, affliction by God or gods and natural causes (Betancourt et al., 2000; Idemudia, 2004; Okafor, 2009; Thomas, 2008). Pioneering studies in the 1970s in Nigeria (Odejide, 1978; Erinsho & Ayorinde, 1978; Prince, 1975) all showed a high prevalence of supernatural causal beliefs relating to witchcraft and curse by enemies with as much as 75% of respondents attributing mental illness solely to an evil spell (Odejide & Olatawaru, 1979). However, increasingly mixed attributions that include biological and psychosocial causations became evident with later studies. For instance, in a study that reviewed the causal beliefs for mental disorders in Lagos metropolis (south-western Nigeria), Ilechukwu (1988) found the majority of respondents attributing their problem to psychosocial

causes and less than half of the patients attributing their problem to supernatural causes. Drug abuse was acknowledged as the leading cause of psychosis in a survey of Kano, northern Nigeria (Iliyasu & Last, 1991). In another study that investigated the knowledge, attitude, causal beliefs, manifestations and treatment of mental illness among adults in a rural northern Nigerian population (Kabir, Iliyasu, Abubakar & Aliyu, 2004), misuse of psychoactive agents (alcohol, cannabis and other street drugs) was the most endorsed causal factor (34.3%) followed by divine punishment (18.8%), magic/spirit possession (18.0%) and accidents/trauma (11.7%) while beliefs in hereditary and life distress as causal factors were uncommon.

Among the Yoruba people in south-western Nigeria, Adebawale and Ogunlesi (1999) found that supernatural explanations were most commonly advanced for mental illness by both sufferers (38.6%) and their relatives (54.3%). However, 17.1% of participants in each group also endorsed medical explanations and 22.9% of patients and 18.6% of their relatives furthermore endorsed psychosocial causations. Ohaeri and Fido (2001) similarly investigated the opinion of relatives of persons with schizophrenia and those with major affective disorder in the same south-western Nigerian region and found their causal attributions for both conditions to be similar; the most endorsed causation being 'Satan's work' (supernatural) (35.8%) followed by 'it is a natural illness' (biological) (23.2%). Increasingly mixed causal explanations became also evident in this region over time. In a study of three states (Ogun, Osun and Oyo) Gureje and colleagues (2005) found that while about a third of the respondents (39.5%) suggested that supernatural factors such as possession by evil spirits and divine punishment could cause mental illness, as much as 80.8% endorsed drug/alcohol misuse, 80% endorsed psychosocial stressors while 46.6% favoured biological causations. A similar proportion of respondents (49%) favoured biological causation in a more recent study that investigated the knowledge of aetiology of mental illness of care-givers of persons with mental illness in a tertiary health institution in the region (Issa, Parakoyi, Yussuf & Musa,

2008). The study also found that 44% endorsed psychosocial causation while 23% favoured supernatural causation. In the most recent study of the region (Adewuya & Makanjuola, 2008), the most endorsed causation was misuse of substances and alcohol (72.3%) followed by evil forces (65.5%) and God's will/divine punishment (50.1%). The study further revealed that while higher educational status, urban dwelling and familiarity with mental illness correlated with belief in psychosocial and biological causation, older age, rural dwelling, and lack of familiarity with person(s) with mental illness were associated with a belief in supernatural causation. Interestingly, educational status made no difference in the endorsement of supernatural causation.

Ewhrudjakpor (2009) investigated the causal beliefs of health workers in Delta, a south-southern Nigerian state and found that 62% attributed mental illness to abuse of psychoactive substances while 30% attributed it to curse/punishment and witches/wizards. However, 75% of the respondents believed that persons with mental illness are evildoers in the form of witches, wizards, voodooists or mischief makers. In a survey of senior hospital staff (excluding nurses) in Uyo, another south-southern Nigeria population, the leading causations were misuse of drugs (89.4%), misuse of alcohol (75.0%), stress (72.1%), genetic inheritance (68.3%) and physical abuse (61.5%). These were endorsed ahead of witches (52.0%), spirit possession (44.2%) and God's punishment (30.0%) (Ukpong & Abasiubong, 2010). Mixed attributions were also evident in a general young Nigerian sample; Furnham and Igboaka (2007) compared the causal beliefs, manifestations and treatment of Schizophrenia in samples of young Nigerians and British participants and reported that while the Nigerians predictably endorsed supernatural causation, they equally favoured biological causation (genetics, brain damage and neurochemical changes) and sociological explanations even more than their British counterparts.

The shift from predominantly supernatural to a more mixed model of attribution is also reported in other parts of Africa. For instance, in Ethiopia, before the 1974 communist

revolution on traditional perception and treatment of mental disorders, it was reported that traditional and religious views were the predominant causal views held for mental illness (Mulatu, 1999; Jacobsson & Merdasa, 1991). These included: disturbances in relationships between people and divinity, possession by evil spirits or punishment by God or guardian spirits for sins, broken taboos or forgotten rituals. Further causations include: curses, spells, or bewitchment by people alleged to have supernatural powers such as the Buda (evil eye), Kallichha (spirit medium, shaman) or Debtera (cleric diviner). More recent surveys however show that psychosocial factors such as stress, drug abuse, and poverty are increasingly being recognized as important risk factors for mental illness (Deribew & Tamirat, 2005). Though twenty-nine traditional healers among the Baganda of Uganda questioned on their beliefs about mental illness all expressed the belief that it was caused by evil spirits, witchcraft, or curses (Ovuga, Boardman, & Oluka, 1999), studies also indicated alternative patterns of attributions. For instance, Okello and Ekblad (2006) reported that the concept of depression varied among the Baganda people depending on the recurrence and severity. Depressive symptoms without psychotic features were associated with “thinking too much” hence causally traceable to the individual. On the other hand, chronic depression was attributed to physical illness such as HIV/AIDS. Depression with psychotic features was considered to be beyond the individual’s control hence its attribution to supernatural forces. In South Africa, cultural groups gave relative salience to the different causal models. In their study of community attitudes towards knowledge of mental illness in Cape Town, Hugo and colleagues (2003) found that although the respondents acknowledged biological causation, most cases were rather conceptualized as stress-related or due to a lack of willpower. On the other hand, a study of the more traditional Xhosa families of patients with schizophrenia found a strong belief that schizophrenia is caused by possession by evil spirits or witchcraft (Mbanga et al., 2002). The majority (95.7%) in a cross-sectional survey of patients and carers attending mental health and non-mental health related clinics in a general hospital in Blantyre, Malawi attributed mental disorder to alcohol and illicit drug abuse. This was followed by

brain disease (92.8%), spirit possession (82.8%) and psychological trauma (76.1%) in an increasingly mixed model of attribution (Crabb et al., 2012).

The foregoing indicates that holding dichotomous view that characterises a group solely in terms of the biopsychosocial or supernatural explanatory model today would not only be too simplistic but also misleading. In an increasingly globalised and secularised world, mixed model of attribution is more typical with societies identifiable at relative points in the spectrum. Landrine and Klonoff (1994) once noted that Western and non-Western respondents did not differ quantitatively in the listing of natural vs. supernatural causes of illness but only in the rating of their importance. While the majority of professionals in a study of Italian population endorsed the biopsychosocial model, a significant minority endorsed magic, spirit possession and spells as causes of schizophrenia (Magliano, Fiorillo, De Rosa, Malangone & Maj, 2004). McLatchie and Draguns (1984) found strong beliefs in demon possession and sin as direct cause of mental illness by evangelical Protestants in the US. Pfeifer (1994) conducted a systematic investigation of the prevalence of belief in demon possession as a cause of mental illness in 343 mainly Protestant out-patients of a psychiatric clinic in Switzerland; 37.6% believed that their problem was possibly caused by the influence of evil spirits (occult bondage or possession) while 30.3% sought help through ritual prayers for deliverance and exorcism.

1.1.3 Rational for Study and Aims

The foregoing supports the suggestion of Ohaeri (1988) that the dominance of traditional conceptualisations in the more traditionalist societies is possibly a phase in the people's historical evolution amenable to change with technological development and improved health literacy. Ground is evidently shifting in the developing world at relative paces from the pre-scientific sole recourse to supernatural explanations to an emergent mixed model with both biological and psychosocial contents. Of the three major socio-cultural groups in Nigeria however, most of the limited research has been carried out among the mixed-faith

(Muslim/Christian) Yoruba group in the south-west with a few among the predominantly Muslim Hausas in the north. The predominantly Christian Igbo group in the south-east is especially under-researched. Filling this gap in knowledge is a major motivation for this study.

The study will furthermore compare the causal beliefs of the Igbo general public in Nigeria with those in the UK with a view to determining the impact of immigration on causal beliefs and the possible implication of immigrants' beliefs on their mental healthcare in a host culture. Polyakova and Pacquiao (2006) had observed that the social and historical contexts of immigrants influence the meaning, attitudes, expressions, and coping strategies toward mental illness. Keynejad (2008) found that ethnic minority groups' causal explanatory models of mental health problems differed conspicuously with the Eurocentric bio-medical model adopted by the UK's National Health Services (NHS). Rarely was any biological cause discussed, with social problems, family difficulties, isolation, life in a different culture or a new country, general stress, substance misuse, psychological problems, spirits and psychiatric medication itself cited as more likely explanations. Young Black African men in the study saw psychotic symptoms as spiritual and identified faith leaders as the appropriate person to seek help from. Many too felt that primary care workers had no expertise in mental health. These represent significant challenges for services to engage ethnic minority groups with culturally appropriate models of mental healthcare. There is very limited research that addresses the psychological impact of immigration on African populations, and West African immigrants particularly face daunting problems as they attempt to settle into Western environments (Thomas, 2008).

The aims of this segment of the research (Study 1) include:

1. To determine the extent to which Igbo people in Nigeria and Igbo people in the UK make supernatural, psychosocial or biological causal attributions for mental illness.
2. To determine the demographic predictors of attributional models.

3. To measure and compare causal beliefs for mental illness across demographic groups.
4. To consider the determinants of given causal explanations.
5. To consider the possible implications of adopting given causal models both in Nigeria and in the UK.

Causal explanatory models influence the symptom presentation of a disorder (Helman, 1990; Weiss, 1996) and have implication for help-seeking behaviours, recommendations for treatment and stigmatising views towards persons with mental illness (Broussard et al., 2010; Muga & Jenkins, 2008; Compton et al., 2006; Carteret, 2011). The trajectory of illness is also influenced by the beliefs patients and doctors hold about course and prognosis (Eisenberg, 1988). Explanatory model, independent of ethnicity, is also associated with treatment satisfaction (Dein, 2002). Hence, dissonance between patients' and therapists' explanatory models may affect culturally sensitive clinical practice, satisfaction and treatment compliance. This segment of the study is conducted in two stages; a preliminary exploratory study (Study 1a) precedes the substantive confirmatory study (Study 1b).

1.2 Methods

1.2.1 Participants and Sampling Technique

For the exploratory study (1a), multi-stage (random and opportunity) sampling was used to select participants ($N = 200$) from Ihiala, a semi-urban Igbo community in Anambra State. The general public was surveyed across the following demographic: Age - the young (18 – 35 years) and the old (>35 years); Gender – males and females; Religious Denomination - Catholics and Protestants; and Educational Status - participants with low education (nil – secondary education) and those with high education (post-secondary education). As a semi-urban town with a fairly representative demographic, Ihiala was chosen as a microcosm of the wider Igbo community. The first stage of sampling involved a random selection of villages,

markets, schools and corporate business establishments in the town through a balloting process. In the second stage, the invitation to participate was extended to people as they were encountered in the selected settings. Questionnaires were administered in each of the four selected settings to the first 50 people who consented to the study thus making a total of 200 respondents.

For the subsequent confirmatory study (1b), a convenience sampling method was used to select participants from across the five Igbo states $n = 1127$ for the Nigeria-based participants and $n = 105$ for the UK-based general public sample. (This sample was used for all the subsequent confirmatory studies across the research). Besides the demographic groups surveyed in the exploratory study, Familiarity (those familiar with persons with mental illness vs. those not familiar with persons with mental illness), Marital Status and Occupation (students, teachers, nurses and the general public) were additionally investigated in the confirmatory study. For the Nigeria-based participants, the survey of students, teachers and nurses took place in their respective institutions across the states. Students were surveyed in classrooms and lecture theatres while teachers were surveyed in staff rooms and offices. Staff nurses were surveyed in hospitals' staff meeting rooms while student nurses were surveyed in their lecture theatres. The general public were mostly interviewed in private homes, business premises and community squares. The UK-resident respondents were recruited mainly from clusters of Igbo unions in the Birmingham and London areas. Contacts were established with the leadership of the unions and dates were agreed on for the survey to be conducted during allocated times in the course of the unions' meetings. Some data collection was also conducted online from networks of Nigerian internet forums.

The age split at 35 years was culturally determined. As Menon (2001) noted, stages of life are conceptualised differently across cultures and times. In many Nigerian cultures, the young develop a sense of adulthood through a series of age-related initiation rites such as the maturity rites among the Igbo people performed by those between 35 and 40 years old, which

symbolises the transition from youth to adulthood (Oko, 2011). In Igbo culture, as in many traditional societies, developmental age, marked by rituals of passage is given more salience than chronological age. Moreover, it is a culture where females are very reticent about disclosing their true (chronological) age while men, conversely, are inclined to exaggerate theirs hence the non-consideration of chronological age in the study. The discrimination of the sample between Catholics and Protestants follows the consideration that over 95% of the people in this region are Christians of either tradition (Agbodike, 2008), with the more independent Protestantism being arguably more indigenised than the Rome-mediated Catholic Church. Familiarity with person(s) with mental illness was considered to compare experiential with conceptive knowledge and also to test the contact hypothesis (Weller & Grunes, 1988) which suggests that contact with persons with mental illness helps to moderate prejudiced views and consequently decreases negative attitudes - a theme that will feature more prominently in the discussion on attitudes towards persons with mental illness (cf. Chapter 2).

1.2.2 Instruments

The research questionnaire introduced by Adewuya and Makanjuola (2008) in their study of lay beliefs about mental illness in a comparable Yoruba culture of south-western Nigeria was adapted for the exploratory study. It consisted of 19 items (see Table 1.1) under 3 subscales representing the 3 (psychosocial, supernatural and biological) causal models. While the biological model consisted of four questionnaire items, the psychosocial and supernatural models had an initial 3 sub-categories each: social factors, abuse of substances and personal deficits; and divine sanction, evil forces and fate respectively. Subsequently, there were 4 questionnaire items on social factors, 2 on abuse of substances and 2 on personal factors. There were 3 on evil forces and 2 items each on divine sanctions and fate.

Table 1.1 Scale items for Exploratory Study on Causal Beliefs

Social Factors	Social factors
	1. Stressful events in a person's life
	2. Trouble in marriage
	3. Financial distress/poverty
	4. Difficulties at work/school
	Abuse of substances
	1. Use of drugs/cannabis
	2. Drinking alcohol in excess
	Personal deficits
	1. Failure in life
	2. Lack of willpower
Supernatural Factors	Divine Sanction
	1. Divine punishment
	2. God's will
	Evil Forces
	1. Witchcraft
	2. Sorcery
	3. Evil spirits
	Fate
	1. Destiny
	2. Bad luck
Bio. Factors	Biological Factors
	1. Heredity
	2. Brain Injury
	3. Infection
	4. Childbirth

A revised version of the scale was used for the confirmatory study 1b (see Table 1.2 below). To revise the scale, qualitative data soliciting the possible causes of mental illness was sourced from the target population. Content analysis was used to create codeable units from the data. The predetermined categories (psychosocial, supernatural and biological) of Adewuya and Makanjuola were retained. The units were defined based on causal idea communicated and each unit was coded to the appropriate causal model. While 15 units came under the psychosocial model, 9 came under the supernatural model and 8 came under the biological model making up the 32 potential items for the quantitative instrument (the process generated 13 new items in addition to those in the original Adewuya and Makanjuola scale). Each of the items was listed with a four-point Likert response scale: strongly agree, agree,

disagree and strongly disagree and respondents were asked to indicate how causally relevant they considered each potential causal item. Participants' response was reclassified as agreeing to the proposition if the response was either 'strongly agree' or 'agree' to the items, and disagreeing with the proposition, if the response was 'strongly disagree' or 'disagree'. Cronbach's alpha and item-total correlations were computed for each of the three sub-scales to check their internal consistency reliability. The supernatural causation subscale demonstrated very good internal consistency reliability with a Cronbach's alpha of 0.90. The psychosocial sub-scale also recorded a very good alpha of 0.84. The biological sub-scale recorded a moderately good alpha of 0.69. The questionnaire was translated into the native Igbo language to complement the English version (see appendix 7). The process involved a back translation. To arrive at the final draft, the translation was reviewed by teachers of either language with inputs from a psychiatric nurse.

Table 1.2 Revised scale for Confirmatory Study on Causal Beliefs

Psychosocial Factors	Social Factors
	1. Loneliness
	2. Stressful experiences in life
	3. Shock
	4. Poverty
	5. Suffering
	6. Frustration
	7. Faulty upbringing
	Abuse of Substances/alcohol
	1. Use of hard drugs/smoking Indian Hemp
	2. Drinking alcohol in excess
	Personal Deficit
	1. Lack of self-control
	2. Anxiety
	3. Failure in life
	4. Immoral lifestyle
	5. Lack of willpower
	6. Being desperate in life
	Divine Sanction
	1. Effect of curses from God/ancestors/holy people or elders
	2. Committing abomination/Nemesis
	3. Breaking of oath/Swearing falsely

	4. Mishandling of spiritual powers
	Evil Forces
	1. Spiritual attack/Witchcraft
	2. Occultism/Belonging to a secret society
	3. Spirit possession
	Fate
	1. Bad luck
	2. Effect of past ancestral rituals/sins
Biological Factors	Biological Factors
	1. Hereditary
	2. Brain Injury
	3. Childbirth
	4. Malnutrition/Hunger
	5. Old age
	6. Drug reaction
	7. Infection
	8. Other sicknesses like High Fever, High Malaria

1.2.3 Data Collection.

Undergraduate students were recruited and trained to help with the administration of the questionnaires in the survey of the Nigeria-based participants. Invitation to participate was extended to prospective participants and those that consented to the study were surveyed. Those who needed help with the pragmatics of completing the questionnaires were provided assistance. The trained assistants had copies of the translated (Igbo) version which they used to orally interview and score those who were not literate or sufficiently proficient in the English language to complete the questionnaire on their own. Most of the questionnaires were completed and collected on the spot. A maximum time frame of one week was accorded those who needed time to complete the questionnaires. While a predetermined 200 participants were recruited for the exploratory study, for the subsequent confirmatory study, a characteristic high response rate of 98% was achieved in the survey of the Nigeria-based sample. This is typical of the collectivist culture that readily rallies round a member who is considered to be undertaking a productive exercise (cf. Odinka et al., 2014). Only 23 of the 1,150 people invited to participate in the study declined participation mostly for being uncomfortable

discussing ‘madness’. Given the limited time allowed for the survey of the UK-based sample in the context of town-hall meetings, many of those who consented to the study but who could not complete the questionnaires on the spot were provided with self-addressed envelopes with which to mail back the completed questionnaires within one week. A significantly lower response was achieved compared to the Nigeria-based survey. Only about a quarter ($n = 86$, 21.5%) of the 400 questionnaires that were distributed were completed and returned and of the 78 online contacts that were made, only 19 (24.4%) completed and returned the questionnaires.

1.2.4 Data Analysis

Data management and statistical analyses were performed using SPSS software version 20.0 (SPSS Inc., Chicago, IL, USA). For all tests performed, the probability value of 0.05 was used as the threshold for determining statistical significance level.

Scoring: Scores were dichotomised so that strongly agree and agree were scored as endorsing a cause and disagree and strongly disagree were scored as indicating non-endorsement of a cause. Scores for individual items were calculated and these were summed to create overall scores for the three causal models.

Descriptive analyses: Both mean scores and percentage endorsed were reported as a function of the demographic variables.

Comparisons: Mean comparisons of the three causal models were by one-way repeated measures ANOVA. Comparisons of the Nigeria and the UK-based (general public) samples were by Independent-samples t-tests.

Tests for relationships: A series of logistic regressions were computed. Total scores on each causal model were dichotomised by a median split, such that endorsement reflected scores above the median. Dichotomised total scores of the models were entered as dependent variables. The independent variables for each logistic regression were the same: age, gender, educational status, religious denomination (for the exploratory study) in addition to

familiarity, marital status and occupation (for the confirmatory study).

1.2.5 Ethical Considerations

The Ethics and Research Committee of the University of Wolverhampton, United Kingdom and that of the University of Nigeria Teaching Hospital, Enugu, Nigeria provided approval for the studies. Permission to survey the nurses and students was sought and obtained from their respective school principals. Written or verbal consent were obtained from prospective participants prior to the administration of the questionnaires. Anonymity and confidentiality were guaranteed.

1.3 Results

1.3.1 Exploratory Study (1a)

The demographic characteristics of the exploratory study sample are summarised in Table 1.3.

Table 1.3 Socio-demographic Characteristics of the Exploratory Study Sample

Characteristics	N	%
Gender		
Male	82	41.0
Female	118	59.0
Age		
Young	112	56.0
Old	88	44.0
Educational Status		
Low education	97	48.5
High education	103	51.5
Religious Denomination		
Protestant	61	30.5
Catholic	139	69.5

There were more respondents in the younger age bracket (56.0%). There were also more females (59.0%) and more Catholics (69.5%). Those that were married (52.5%) were marginally more than those that were not married. Similarly, those with high education were marginally more (51.5%) than those with low education.

Table 1.4 Descriptive Statistics for Causal Attributions of Mental Illness (Exploratory Study1a)

Psychosocial factors	<i>n</i>	%	<i>M</i>	<i>SD</i>
Social Factors	134	66.8	2.23	.68
Misuse of Substances	194	96.9	3.14	.81
Personal Deficit	96	47.9	1.96	.62
Psychosocial causes overall	162	80.9	2.34	.45

Supernatural factors				
Divine Sanction	131	65.4	2.43	1.16
Evil Forces	191	95.3	3.26	.83
Fate	97	48.4	1.99	1.02
Supernatural causes overall	180	90.0	2.69	.72
Biological factors				
Hereditary	174	86.8	3.08	1.11
Brain injury	186	93.0	3.43	.93
Childbirth/infection	54	27.1	1.47	.84
Biological causes overall	170	85.1	2.36	.48

The pattern of perceived causation of mental illness (as illustrated in Table 1.4) showed that the most frequently endorsed causal category was ‘misuse of substances’ (96.9%) followed by evil forces (95.3%), brain injury (93.0%) and hereditary (86.8%). Childbirth/infection (27.1%), personal deficit (47.9%) and fate (48.4%) were the least endorsed causations. However, the true weights of the models were computed by calculating the mean scores of the constituent categories. This indicates that the supernatural causal model had the highest endorsement ($M = 2.69$, $SD = .72$), followed by the biological model ($M = 2.36$, $SD = .48$) and the psychosocial model ($M = 2.34$, $SD = .45$). A one-way repeated measures ANOVA was used to compare the means. Mauchly’s test indicated that the assumption of sphericity had been violated ($\chi^2(2) = 24.99$, $p < .001$) therefore, degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\varepsilon = .87$). The results showed that there was significant difference in the endorsement of causal models $F(1.74, 267.67) = 26.85$; $p < .001$; partial eta sq = .15). Post hoc Bonferonni tests indicated that supernatural attributions were made more than psychosocial attributions ($p < .001$) and biological attributions ($p < .001$), but there was no significant difference in the endorsement of psychosocial and biological causations.

Direct logistic regressions were performed on the data to determine the impact of the independent variables on the likelihood of endorsing particular causations.

Table 1.5

Logistic Regression predicting the likelihood of endorsing divine sanction (supernatural causal model).

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
age	1.20	.33	12.99	1	.00	3.33	1.73	6.40
gender	-.80	.34	5.53	1	.02	.45	.23	.88
denomination	-.03	.36	.01	1	.94	.97	.48	1.95
education	-.36	.32	1.28	1	.26	.70	.37	1.30
Constant	-.85	.37	5.29	1	.02	.43		

A test of the full model against a constant only model was statistically significant (X^2 (4, N = 200) = 19.09, $p < .01$), indicating that the model was able to distinguish between respondents who are likely to endorse or not endorse the supernatural category 'Divine Sanction'. The model as a whole explained between 9.1% (Cox and Snell R square) and 12.8% (Nagelkerke R squared) of the variance and correctly classified 70.5% of cases. As shown in Table 1.5, age made a statistically significant contribution to the endorsement of Divine Sanction ($B = 1.20$, $Wald = 12.985$, $p < .001$), indicating that the old are more likely to endorse God's will and divine punishment than the young with an odds ratio of 3.33. Gender also made a statistically significant contribution to the endorsement of 'Divine Sanction' ($B = -.802$, $Wald = 5.527$, $p < .05$), indicating that females are more likely to endorse God's will and divine punishment than males with an odds ratio of 0.45.

Table 1.6

Logistic Regression predicting the likelihood of endorsing fate (supernatural causal model).

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
age	1.40	.39	12.95	1	.00	4.05	1.89	8.68
gender	-.81	.39	4.23	1	.04	.45	.21	.96
denomination	.23	.42	.29	1	.59	1.26	.55	2.89
education	-.31	.37	.72	1	.40	.73	.36	1.50
Constant	-1.78	.45	15.41	1	.00	.17		

The full model containing all the predictors was also statistically significant (X^2 (4, N = 200) = 19.13, $p < .05$), indicating that the model was able to distinguish between respondents who are likely to endorse or not endorse the supernatural category 'Fate'. The model as a whole explained between 9.1% (Cox and Snell R square) and 14.2% (Nagelkerke R squared) of the

variance and correctly classified 79.0% of cases. As shown in Table 1.6, age also made a statistically significant contribution to the endorsement of Fate ($B = 1.40$, $Wald = 12.95$, $p < .001$) indicating that the old are more likely to endorse destiny and bad luck than the young with an odds ratio of 4.05. Gender also made a statistically significant contribution to the endorsement of Fate ($B = -.81$, $Wald = 4.23$, $p < .05$), indicating that females are more likely to attribute mental illness to destiny and bad luck than males with an odds ratio of .45.

Table 1.7

Logistic Regression predicting the likelihood of endorsing supernatural causal model.

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
age	.16	.30	.27	1	.61	1.17	.65	2.11
gender	-.40	.30	1.74	1	.19	.67	.37	1.22
denom	-.23	.32	.51	1	.47	.79	.42	1.49
education	-.82	.29	7.83	1	.01	.44	.25	.78
Constant	.44	.34	1.68	1	.20	1.55		

The full model containing all the predictors was also statistically significant ($X^2(4, N = 200) = 10.11$, $p < .05$), indicating that the model was able to distinguish between respondents who are likely to endorse or not endorse supernatural causal model. The model as a whole explained between 4.9% (Cox and Snell R square) and 6.6% (Nagelkerke R squared) of the variance and correctly classified 60.0% of cases. As shown in Table 1.7, level of education made a unique statistically significant contribution to the endorsement of the supernatural model ($B = -.82$, $Wald = 7.83$, $p < .05$), indicating that those with low education are more likely to endorse supernatural causations than those with higher education with odds ratio of .44.

Table 1.8

Logistic Regression predicting the likelihood of endorsing social factors (psychosocial causal model)

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
age	.11	.33	.11	1	.74	1.12	.58	2.14
gender	-.38	.38	1.29	1	.26	.68	.35	1.32
denomination	.85	.39	4.68	1	.03	2.33	1.08	5.01
education	.68	.33	4.17	1	.04	1.97	1.03	3.77
Constant	-1.85	.43	18.77	1	.00	.16		

The full model was also statistically significant ($X^2(4, N = 200) = 10.34$, $p < .05$), indicating that the model was able to distinguish between respondents who are likely to endorse or not

endorse social factors. The model as a whole explained between 5.0% (Cox and Snell R square) and 7.3% (Nagelkerke R squared) of the variance and correctly classified 72% of cases. As shown in Table 1.8, religious denomination made a statistically significant contribution to the endorsement of social factors ($B = .85$, $Wald = 4.68$, $p < .05$), indicating that the Catholics are more likely to attribute mental illness to life stresses than the Protestants with an odds ratio of 2.33. Level of education also made a statistically significant contribution to the endorsement of social factors ($B = .68$, $Wald = 4.17$, $p < .05$), indicating that those with higher education are more likely to attribute mental illness to life stresses compared to those with low education with an odds ratio of 1.97.

Table 1.9

Logistic Regression predicting the likelihood of endorsing personal factors (psychosocial causal model).

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
age	1.41	.62	5.26	1	.02	4.10	1.23	13.66
gender	-.15	.55	.07	1	.77	.86	.29	2.53
denomination	1.02	.79	1.67	1	.20	2.77	.59	12.95
education	.88	.58	2.33	1	.13	2.40	.78	7.41
Constant	-4.54	.94	23.56	1	.00	.01		

The full model containing all the predictors was also statistically significant ($X^2(4, N = 200) = 10.34$, $p < .05$), indicating that the model was able to distinguish between respondents who are likely to endorse or not endorse personal factors. The model as a whole explained between 5.5% (Cox and Snell R square) and 12.8% (Nagelkerke R squared) of the variance and correctly classified 92% of cases. As shown in Table 1.9, age made a unique statistically significant contribution to the endorsement of personal factors ($B = 1.41$, $Wald = 5.26$, $p < .05$), indicating that the old are more likely to attribute mental illness to failure in life and lack of will power than the young with odds ratio of 4.10.

Table 1.10*Logistic Regression predicting the likelihood of endorsing psychosocial causal model.*

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
age	-.23	.32	.49	1	.48	.80	.43	1.50
gender	-.33	.32	1.03	1	.31	.72	.38	1.36
denom	.44	.35	1.54	1	.21	1.55	.78	3.08
education	.80	.32	6.35	1	.01	2.22	1.19	4.13
Constant	-1.26	.38	11.13	1	.00	.28		

The full model containing all the predictors was also statistically significant ($X^2(4, N = 200) = 9.66, p < .05$), indicating that the model was able to distinguish between respondents who are likely to endorse or not endorse psychosocial causal model. The model as a whole explained between 4.7% (Cox and Snell R square) and 6.6% (Nagelkerke R squared) of the variance and correctly classified 67.5% of cases. As shown in Table 1.10, level of education made a unique statistically significant contribution to the endorsement of the psychosocial model ($B = .80$, $Wald = 6.35, p < .05$), indicating that those with higher education are more likely to endorse psychosocial causations than those with low education with odds ratio of 2.22.

1.3.2 Confirmatory Study (1b)

The demographic characteristics of the confirmatory study sample are summarised in Table 1.11.

Table 1.11 Socio-demographic Characteristics of the Confirmatory Study Sample

Characteristics		Nigeria-based		UK-based	
		N	%	N	%
Gender	Female	773	69.0	50	47.6
	Male	374	31.0	55	52.4
Age	Young	794	71.3	26	25.5
	Old	319	28.7	76	74.5
Marital Status	Not married	690	62.1	24	25.8
	Married	422	37.9	69	74.2
Educational Status	Low educ.	208	18.6	12	12.6
	High educ.	909	81.4	83	87.4
Religious Denomination	Protestant	453	41.9	16	16.3
	Catholic	629	58.1	82	83.7
Familiarity	Not familiar	366	35.5	28	31.8
	Familiar	664	64.5	60	68.2
Occupation	Students	229	20.3		
	Teachers	276	24.5		
	General Public	268	23.9	105	100
	Nurses	317	28.1		

There were more female respondents (69.0%) and more in the younger age bracket (71.3%) in the Nigeria-based sample. The majority of the respondents were not married (62.1%). About

four in five of the respondents (81.4%) had higher education. There were more Catholics (58.1%) and close to two-thirds of the respondents (64.5%) were familiar with persons with mental illness. The occupational variables were fairly distributed. However, among the UK-based general public, there were marginally more male respondents (52.4%) and more in the older age bracket (74.5%). The majority of the respondents were married (74.2%). Over four in five (87.4%) had higher education. There were more Catholics (83.7%) and two-thirds (68.2%) were familiar with persons with mental illness.

Table 1.12 Descriptive Statistics for Causal Attributions of Mental Illness (Confirmatory Study 1b)

Demographic Variables		Psychosocial Causation										Supernatural Causation									
		Social Stressors		Abuse of Substances		Personal Factors		Total Psychosocial Causation				Divine Sanction		Evil Forces		Fate		Total Supernatural Causation			
		N	%	N	%	N	%	N	%	Mean	SD	N	%	N	%	N	%	N	%	Mean	SD
Gender	Female	571	79.5	736	96.8	488	66.8	553	81.7	2.91	.45	620	83.3	612	81.4	550	73.0	564	78.7	3.02	.68
	Male	240	73.6	320	94.1	196	59.8	238	76.5	2.80	.43	310	90.9	308	89.0	273	81.0	295	88.9	3.16	.57
Age	Young	596	79.5	758	96.0	499	66.0	588	82.2	2.90	.44	637	82.5	629	80.5	560	72.4	580	77.6	3.00	.70
	Old	214	73.8	298	96.1	184	62.2	203	75.5	2.82	.46	288	94.1	286	91.7	257	83.2	274	92.3	3.24	.49
Marital Status	Not Married	530	81.0	655	96.0	439	66.7	520	83.1	2.91	.44	558	83.0	546	80.5	481	71.9	501	77.6	2.98	.70
	Married	276	71.9	394	96.1	242	61.7	267	75.0	2.82	.46	367	90.6	366	88.8	336	81.2	352	88.9	3.19	.54
Educational Status	Low Educ.	137	71.0	194	96.5	110	57.3	130	73.0	2.79	.49	191	95.0	186	92.5	159	81.1	172	91.5	3.23	.53
	High Educ.	673	79.3	860	96.0	578	66.8	664	82.0	2.90	.44	736	83.5	730	81.7	660	74.1	683	79.6	3.06	.65
Religious Denomination	Protestant	330	78.4	432	96.6	266	61.9	322	80.9	2.88	.42	375	85.4	385	86.1	331	74.9	350	82.0	3.08	.64
	Catholic	456	77.9	589	95.6	396	66.8	447	80.5	2.88	.46	525	86.2	506	82.4	466	76.1	482	82.1	3.06	.66
Familiarity	Not Familiar	262	76.8	342	95.0	197	57.8	245	76.3	2.81	.43	312	87.6	317	88.1	276	78.2	287	83.2	3.10	.61
	Familiar	495	7.2	635	96.9	431	67.9	495	82.8	2.92	.46	541	84.3	524	80.7	475	73.1	498	80.3	3.03	.68
Occupation	Teachers	183	74.1	248	92.5	170	66.4	180	78.6	2.84	.44	236	89.7	245	91.1	220	82.4	228	89.8	3.20	.54
	Students	161	73.2	219	96.5	129	59.7	163	78.0	2.83	.45	210	94.6	201	90.1	175	80.6	190	91.3	3.23	.53
	Nurses	273	90.4	309	98.1	236	76.6	264	89.8	3.05	.42	206	66.7	196	63.0	172	55.0	173	57.5	2.65	.76
Gen. Public		173	70.0	255	97.3	139	55.6	167	72.9	2.75	.43	251	95.8	254	95.1	232	87.5	245	94.6	3.26	.46
Overall Score (Nig-based)		817	77.7	1063	96.0	690	64.8	798	80.2	2.88	.45	937	85.8	926	83.8	829	75.6	865	81.9	3.06	.65
UK (General public) sample		64	61.5	98	96.1	54	53.5	65	66.3	2.67	.49	74	72.5	79	77.5	69	67.0	71	72.4	2.86	.70

Table 1.12 continued: Descriptive Statistics for Causal Attributions of Mental Illness (Confirmatory Study)

Demographic Variables		Biological Causation																			
		Hereditary		Brain Injury		Childbirth		Malnutrition /Hunger		Old age		Drug reaction		Infection		Other medical conditions		Total Biological Causation			
		<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	Mean	SD
Gender	Female	652	84.7	741	95.9	424	55.1	274	35.9	339	44.2	651	85.1	400	52.1	559	75.6	578	80.7	2.86	.48
	Male	292	85.1	331	95.7	152	44.7	127	37.0	162	47.0	312	90.2	177	51.2	231	69.8	261	81.6	2.83	.43
Age	Young	666	84.4	757	95.5	428	54.5	307	39.1	389	49.2	677	85.8	414	52.3	541	71.1	601	81.3	2.87	.47
	Old	272	86.1	309	96.9	144	45.4	92	29.2	107	34.0	280	88.9	156	49.4	243	80.5	229	79.2	2.80	.44
Marital Status	Not Married	584	85.1	662	96.1	366	53.7	267	39.1	343	50.0	592	86.5	361	52.5	457	69.5	517	80.8	2.87	.48
	Married	354	84.7	404	95.7	205	48.9	133	31.9	153	36.4	366	87.4	213	50.8	330	89.5	315	80.8	2.82	.44
Educational Status	Low Educ.	176	85.0	195	94.2	88	43.1	69	33.5	98	47.6	187	90.8	99	48.1	145	72.9	152	78.8	2.83	.47
	High Educ.	766	84.9	874	96.1	486	53.9	333	37.1	402	44.5	774	85.8	478	52.8	645	74.3	685	81.6	2.85	.46
Religious Denomination	Protestant	366	81.5	431	95.4	223	49.8	153	34.5	196	43.8	388	86.8	229	51.1	315	72.4	335	80.1	2.84	.46
	Catholic	550	88.0	605	96.2	340	54.6	236	37.8	290	46.3	540	86.3	327	52.1	452	75.3	472	81.1	2.87	.47
Familiarity	Not Familiar	293	80.9	347	94.8	179	49.4	119	33.0	140	38.5	314	86.3	175	47.9	241	69.5	265	79.3	2.80	.45
	Familiar	578	87.4	639	96.2	358	54.3	247	37.5	320	48.5	570	86.4	351	53.2	481	75.3	506	81.4	2.88	.47
Occupation	Teachers	226	82.5	263	95.3	119	43.3	91	33.6	113	41.2	244	89.7	139	50.5	195	75.6	199	79.9	2.79	.42
	Students	184	80.7	222	96.9	109	48.4	80	35.2	101	44.5	205	89.9	110	48.2	128	58.7	161	77.0	2.80	.48
	Nurses	278	88.0	305	96.2	220	69.6	137	43.8	164	52.1	252	80.0	189	59.8	242	78.8	260	86.1	2.96	.49
Gen. public		230	86.8	254	94.8	113	42.5	85	31.8	112	41.9	234	87.6	125	46.8	211	80.8	202	80.2	2.81	.43
Overall Score Nig-based		950	84.9	1079	95.8	579	51.9	404	36.3	503	45.0	969	86.7	580	51.7	796	73.9	842	80.8	2.85	.46
UK (General public) sample		88	84.6	97	93.3	49	47.1	27	26.7	43	41.7	90	86.5	58	55.8	61	59.8	76	76.8	2.76	.40

The pattern of perceived causation of mental illness as endorsed by the respondents (Table 1.12) showed that among the most highly endorsed causal items were abuse of substances/alcohol (Nigeria-based = 96.0%, UK-based = 96.1%), brain injury (Nigeria-based = 95.8%, UK-based = 93.3%), drug reaction (Nigeria-based = 86.7%, UK-based = 86.5%), divine sanction (Nigeria-based = 85.8%, UK-based = 72.5%), hereditary (Nigeria-based = 84.9%, UK-based = 84.6%) and evil forces (Nigeria based = 83.8%, UK-based = 77.5%). Conversely, among the least endorsed causations were malnutrition/hunger (Nigeria-based = 36.3%, UK-based = 26.7%), old age (Nigeria-based = 45.0%, UK-based = 41.7%) and childbirth (Nigeria-based = 51.9%, UK-based = 47.1%). The percentage cumulative endorsement scores of the causal models by the Nigeria-based sample were: supernatural 81.9%, biological 80.8% and psychosocial 80.2%. However, the true weight of the models as demonstrated by the cumulative mean scores showed that the supernatural model received the highest endorsement ($M = 3.06$, $SD = .65$), followed by the psychosocial ($M = 2.88$, $SD = .45$) and biological models ($M = 2.85$, $SD = .46$). A one-way repeated measures ANOVA was conducted to compare the scores. Mauchly's test showed that the assumption of sphericity was violated ($\chi^2(2) = 339.33$, $p < .001$); therefore degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\epsilon = .76$). The results showed that there was significant difference in the endorsement of causal models $F(1.52, 1354.89) = 44.31$; $p < .001$; partial eta sq. = 0.05. Post hoc Bonferroni tests confirmed that the supernatural model was significantly more endorsed than the psychosocial ($p < .001$) and biological models ($p < .001$). However, there was no significant difference in the endorsement of the psychosocial and biological models.

The percentage cumulative endorsement scores of the causal models by the UK-based sample were: biological 76.8%, supernatural 72.4% and psychosocial 66.3%. However, the true weight of the models as demonstrated by the cumulative mean scores showed that the supernatural model received the highest endorsement ($M = 2.86$, $SD = .70$), followed by the

biological ($M = 2.76$, $SD = .41$) and psychosocial model ($M = 2.67$, $SD = .49$). A one-way repeated measures ANOVA was also conducted to compare the means. Mauchly's test showed that the assumption of sphericity was violated ($\chi^2(2) = 27.17$, $p < .001$); therefore degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\epsilon = .79$). The results showed that there was no significant difference in the endorsement of the three causal models $F(1.58, 140.64) = 2.31$; $p = ns$. An independent sample t-test showed that the difference in the endorsement of supernatural causation by the Nigeria-based (general public) sample ($M = 3.06$, $SD = .46$) and the UK-based (general public) sample ($M = 2.86$, $SD = .70$) was statistically significant, $t(355) = 5.32$, $p = .001$, (two-tailed). The magnitude of the differences in the means (mean difference = .40, 95% *CI*: .25 to .55) was moderate (eta squared = .07).

Direct logistic regressions were performed on the data to determine the impact of the independent variables on the likelihood of endorsing particular causations.

Table 1.13

Logistic Regression predicting the likelihood of endorsing divine sanction (supernatural causal model).

	B	S.E.	Wald	df	P	Odds Ratio	95.0% C.I. for Odds Ratio	
							Lower	Upper
gender	-.35	.29	1.47	1	.23	.704	.40	1.24
age	.73	.40	3.31	1	.07	2.07	.95	4.51
marital status	-.15	.29	.29	1	.60	.86	.49	1.51
education	-.13	.45	.08	1	.78	.88	.36	2.12
nurses vs. students	2.31	.43	29.44	1	.00	10.04	4.36	23.10
nurses vs. teachers	1.24	.33	14.21	1	.00	3.46	1.82	6.60
nurses vs. gen. public	2.31	.45	26.09	1	.00	10.03	4.14	24.29
denomination	-.04	.21	.04	1	.84	.96	.64	1.43
contact	.11	.22	.23	1	.63	1.11	.72	1.71
Constant	.90	.48	3.50	1	.06	2.47		

A test of the full model against a constant only model was statistically significant, indicating that the model was able to distinguish between respondents who are likely to endorse or not endorse divine sanction, $X^2(9, N = 895) = 110.23$, $p < .001$. The model as a whole explained between 11.6% (Cox and Snell R square) and 20.4% (Nagelkerke R squared) of the variance and correctly classified 85.3% of cases. As shown in Table 1.13 only occupation made a significant contribution to the endorsement of divine sanction: nurses were significantly less

likely to attribute mental illness to divine sanction than students ($B = 2.31$, $Wald = 29.44$, $p < .001$) with an odds ratio of 10.04. Nurses were also significantly less likely to attribute mental illness to divine sanction than teachers ($B = 1.24$, $Wald = 14.21$, $p < .001$) with an odds ratio of 3.46. Nurses were furthermore significantly less likely to attribute mental illness to divine sanction than the general public ($B = 2.31$, $Wald = 26.09$, $p < .001$) with an odds ratio of 10.03.

Table 1.14

Logistic Regression predicting the likelihood of endorsing evil forces (supernatural causal model).

	B	S.E.	Wald	df	P	Odds Ratio	95.0% C.I. for Odds Ratio	
							Lower	Upper
gender	-.11	.27	.16	1	.69	.90	.53	1.53
age	.16	.36	.19	1	.66	1.17	.57	2.39
marital status	-.16	.28	.31	1	.58	.86	.50	1.48
education	-.05	.39	.01	1	.91	.96	.45	2.04
nurses vs. students	1.82	.35	26.70	1	.00	6.16	3.09	12.289
nurses vs. teachers	1.76	.34	27.02	1	.00	5.81	2.99	11.28
nurses vs. gen. public	2.48	.42	35.10	1	.00	12.00	5.27	27.28
denomination	-.47	.20	5.52	1	.02	.63	.43	.93
contact	.37	.21	3.03	1	.08	1.45	.95	2.21
Constant	.78	.42	3.39	1	.07	2.17		

A test of the full model was also statistically significant indicating that the model was able to distinguish between respondents who are likely to endorse or not endorse evil forces, $X^2 (9, N = 908) = 125.69$, $p < .001$. The model as a whole explained between 12.9% (Cox and Snell R square) and 21.6% (Nagelkerke R squared) of the variance and correctly classified 82.9% of cases. Occupation was the strongest predictor of the endorsement of evils forces (see Table 1.14). Nurses were significantly less likely to attribute mental illness to evil forces than students ($B = 1.82$, $Wald = 26.70$, $p < .001$) with an odds ratio of 6.16. Nurses were also significantly less likely to attribute mental illness to evil forces than teachers ($B = 1.76$, $Wald = 27.02$, $p < .001$) with an odds ratio of 5.81. Nurses were furthermore significantly less likely to attribute mental illness to evil forces than the general public ($B = 2.48$, $Wald = 35.10$, $p < .001$) with an odds ratio of 11.99. Religious denomination also made significant contribution to the model. The Protestants were significantly more likely to endorse evil forces than the Catholics ($B = -.466$, $Ward = 5.52$, $p < .05$) with an odds ratio of .63.

Table 1.15*Logistic Regression predicting the likelihood of endorsing fate (supernatural causal model).*

	B	S.E.	Wald	df	P	Odds Ratio	95.0% C.I. for Odds Ratio	
							Lower	Upper
gender	-.22	.21	1.08	1	.30	.81	.53	1.21
age	.02	.29	.00	1	.95	1.02	.58	1.79
marital status	-.16	.24	.42	1	.52	.85	.53	1.38
education	.27	.26	1.02	1	.31	1.31	.78	2.19
nurses vs. students	1.31	.26	24.77	1	.00	3.71	2.21	6.21
nurses vs. teachers	1.47	.27	29.37	1	.00	4.34	2.55	7.37
nurses vs. gen. public	1.97	.31	39.66	1	.00	7.16	3.88	13.22
denomination	.02	.16	.02	1	.89	1.02	.74	1.41
contact	.14	.18	.60	1	.44	1.15	.81	1.61
Constant	-.05	.30	.03	1	.87	.95		

The full model containing all the predictors was also statistically significant in predicting the endorsement of fate, X^2 (9, N = 902) = 85.801, $p < .001$. The model as a whole explained between 9.1% (Cox and Snell R square) and 13.3% (Nagelkerke R squared) of the variance and correctly classified 74.3% of cases. Only occupational group was significant predictor (see Table 1.15): nurses were significantly less likely to attribute mental illness to fate than students ($B = 1.31$, Wald = 24.77, $p < .001$) with an odds ratio of 3.71. Nurses were also significantly less likely to attribute mental illness to fate than teachers ($B = 1.47$, Wald = 29.37, $p < .001$) with an odds ratio of 4.34. Nurses were furthermore significantly less likely to attribute mental illness to fate than the general public ($B = 1.97$, Wald = 39.66, $p < .001$) with an odds ratio of 7.16.

Table 1.16*Logistic Regression predicting the likelihood of endorsing supernatural causal model.*

	B	S.E.	Wald	df	P	Odds Ratio	95.0% C.I. for Odds Ratio	
							Lower	Upper
gender	-.07	.27	.06	1	.80	.93	.55	1.59
age	.57	.37	2.31	1	.13	1.76	.85	3.67
marital status	-.02	.28	.01	1	.95	.98	.57	1.69
education	.07	.38	.04	1	.85	1.08	.51	2.28
nurses vs. students	2.16	.36	35.87	1	.00	8.68	4.28	17.60
nurses vs. teachers	1.60	.32	25.07	1	.00	4.95	2.65	9.25
nurses vs. gen. public	2.35	.41	33.55	1	.00	10.46	4.73	23.15
denomination	-.08	.19	.16	1	.69	.93	.64	1.35
contact	-.04	.21	.04	1	.85	.96	.64	1.44
Constant	.31	.42	.56	1	.45	1.37		

The full model containing all the predictors was statistically significant in the prediction of supernatural causation as a model, X^2 (9, N = 867) = 141.68, $p < .001$. The model as a whole explained between 15.1% (Cox and Snell R square) and 24.5% (Nagelkerke R squared) of the

variance and correctly classified 81.0% of cases. Only occupational group was a significant predictor (see Table 1.16): nurses were significantly less likely to attribute mental illness to supernatural causation than students ($B = 2.161$, $Wald = 35.871$, $p < .001$) with an odds ratio of 8.68. Nurses were also significantly less likely to attribute mental illness to supernatural causation than teachers ($B = 1.599$, $Wald = 25.065$, $p < .001$) with an odds ratio of 4.95. Nurses were furthermore significantly less likely to attribute mental illness to supernatural causation than the general public ($B = 2.348$, $Wald = 33.550$, $p < .001$) with an odds ratio of 10.46.

Table 1.17

Logistic Regression predicting the likelihood of endorsing social factors (psychosocial causal model).

	B	S.E.	Wald	df	P	Odds Ratio	95.0% C.I. for Odds Ratio	
							Lower	Upper
gender	-.13	.20	.46	1	.50	.88	.607	1.29
age	.38	.27	2.03	1	.15	1.46	.87	2.46
marital status	-.69	.25	7.35	1	.01	.50	.31	.826
education	.22	.22	.95	1	.33	1.25	.80	1.93
nurses vs. students	-1.11	.30	14.01	1	.00	.33	.18	.59
nurses vs. teachers	-1.12	.30	14.12	1	.00	.33	.18	.59
nurses vs. gen. public	-1.24	.31	15.94	1	.00	.29	.16	.53
denomination	.12	.18	.49	1	.48	1.13	.80	1.60
contact	-.10	.18	.31	1	.58	.90	.63	1.29
Constant	2.19	.32	46.32	1	.00	8.96		

A test of the full model against a constant only model was statistically significant indicating that the model was able to distinguish between respondents who were likely to endorse social factors and those who were not, $X^2 (9, N = 867) = 54.95$, $p < .001$. The model as a whole explained between 6.1% (Cox and Snell R square) and 9.5% (Nagelkerke R squared) of the variance and correctly classified 78.8% of cases. Occupation was the strongest predictor of the endorsement of social factors (see Table 1.17). Nurses were significantly more likely to attribute mental illness to social factors than students ($B = -1.11$, $Wald = 14.01$, $p < .001$) with an odds ratio of .33. Nurses were also significantly more likely to attribute mental illness to social factors than teachers ($B = -1.12$, $Wald = 14.12$, $p < .001$) with an odds ratio of .33. Nurses were furthermore significantly more likely to attribute mental illness to social factors than the general public ($B = -2.42$, $Wald = 15.941$, $p < .001$) with an odds ratio of .29. Marital status also made significant contribution to the endorsement of social factors. Those that were

not married were significantly more likely to endorse social factors than those who were married ($B = -.690$, $Wald = 7.35$, $p < .01$) with an odds ratio of .50.

Table 1.18

Logistic Regression predicting the likelihood of endorsing personal factors (psychosocial causal model)

	B	S.E.	Wald	df	P	Odds Ratio	95.0% Ratio C.I.	for Odds
							Lower	Upper
gender	-.10	.17	.36	1	.55	.90	.64	1.27
age	.13	.24	.31	1	.58	1.14	.72	1.83
marital status	-.31	.22	1.98	1	.16	.73	.48	1.13
education	.28	.21	1.82	1	.18	1.32	.88	1.97
nurses vs. students	-.54	.23	5.23	1	.02	.59	.37	.93
nurses vs. teachers	-.50	.24	4.46	1	.04	.61	.38	.97
nurses vs. gen. public	-.72	.25	8.30	1	.00	.49	.30	.79
denomination	.20	.15	1.83	1	.18	1.22	.91	1.63
contact	-.36	.15	5.48	1	.02	.70	.52	.94
Constant	.95	.26	13.28	1	.00	2.59		

A test of the full model against a constant only model was also statistically significant indicating that the model was able to distinguish between respondents who are likely to endorse personal factors and those who are not, $X^2 (9, N = 879) = 38.24$, $p < .001$. The model as a whole explained between 4.3% (Cox and Snell R square) and 5.9% (Nagelkerke R squared) of the variance and correctly classified 66.3% of cases. Occupation was the strongest predictor of the endorsement of personal factors (see Table 1.18). Nurses were significantly more likely to attribute mental illness to personal factors than students ($B = -.536$, $Wald = 5.23$, $p < .05$), with an odds ratio of .59. Nurses were also significantly more likely to attribute mental illness to personal factors than teachers ($B = -.50$, $Wald = 4.46$, $p < .05$), with an odds ratio of .61. Nurses were furthermore significantly more likely to attribute mental illness to personal factors than the general public ($B = -.72$, $Wald = 8.30$, $p < .05$), with an odds ratio of .49. Familiarity with people with mental illness also made significant contribution to the endorsement of social factors. Those who are not familiar with people with mental illness were significantly more likely to endorse personal causations than those who are familiar with people with mental illness ($B = -.359$, $Wald = 5.48$, $p < .05$), with an odds ratio of .70.

Table 1.19*Logistic Regression predicting the likelihood of endorsing psychosocial causal model.*

	B	S.E.	Wald	df	P	Odds Ratio	95.0% C.I. for Odds Ratio	
							Lower	Upper
gender	-.13	.21	.40	1	.53	.87	.58	1.33
age	.19	.28	.43	1	.51	1.20	.69	2.10
marital status	-.61	.27	5.03	1	.03	.55	.32	.93
education	.54	.24	4.94	1	.03	1.72	1.07	2.78
nurses vs. students	-.46	.31	2.15	1	.14	.63	.35	1.17
nurses vs. teachers	-.69	.31	5.12	1	.03	.50	.28	.91
nurses vs. gen. public	-.69	.32	4.59	1	.03	.50	.27	.94
denomination	-.00	.19	.00	1	.99	1.00	.69	1.45
contact	-.29	.19	2.18	1	.14	.75	.52	1.10
Constant	1.84	.33	30.31	1	.00	6.27		

The full model containing all the predictors was statistically significant in predicting the endorsement of psychosocial causations $X^2 (9, N = 826) = 17.26, p < .001$. The model as a whole explained between 4% (Cox and Snell R square) and 7% (Nagelkerke R squared) of the variance and correctly classified 81.4% of cases. Three of the independent variables made statistically significant contribution to the overall endorsement of the psychosocial causal model with the highest predictor being occupational group (See Table 1.19): nurses were significantly more likely to attribute mental illness to psychosocial factors than teachers ($B = -.689, Wald = 5.12, p < .05$) with an odds ratio of .50. Nurses were also significantly more likely to attribute mental illness to psychosocial factors than the general public ($B = -.694, Wald = 4.589, p < .05$) with an odds ratio of .50. Level of education was also a significant predictor. Participants with higher education were significantly more likely to endorse psychosocial causations than those with low education ($B = .542, Wald = 4.938, p < .026$) with an odds ratio of 1.72. Marital status also made a statistically significant contribution to the endorsement of psychosocial causation. Participants who are not married are significantly more likely to endorse the psychosocial causations than those that are married ($B = -.606, Wald = 5.03, p < .05$) with an odds ratio of .55.

1.4 Discussion

This study investigated the extent to which the Igbo people of south-eastern Nigeria make supernatural, psychosocial and biological explanations for mental illness. The demographic distribution of the Nigeria-based sample showed that there were more female respondents

which is attributable to nurses (one of the four occupational groups surveyed) typically being made up of mostly females. There were also more respondents in the younger age bracket which fundamentally reflects the current Nigerian demographic distribution but which was also reinforced by the selection of students as one of the surveyed occupational groups. These factors also contributed to the higher number of those that were not married compared to those that were married. There were more respondents with higher education which is largely due to teachers (another occupational group surveyed) and nurses falling under the higher education category. There were more Catholics than Protestants which reflects the predominance of Catholics in this part of Nigeria. The majority of the respondents were familiar with persons with mental illness. This could be attributed to the common spectacle of vagrants suffering with psychosis in neighbourhoods and market squares in this region. The presence of the only federal government-owned Neuropsychiatric Hospital (Enugu) through which nurses pass for their compulsory psychiatric experience is also a likely contributory factor. On the other hand, among the UK based general public sample, there were more males, more in the older age bracket and more that are married. These could be traced to migration. World Migration Report (2013) indicates that men generally migrate more than women especially in the developing countries. Migrants from the south also represent a higher share of the older age group compared to the nationals. Being in the older age bracket may have contributed to the majority of migrants being married. It also seems culturally less acceptable for women to move about and travel on their own in Africa.

The study found significantly mixed attribution in both the exploratory and confirmatory studies and by both the Nigeria and the UK based samples; more than half of the respondents in each group endorsed each of the three causal models. This reflects a holistic view of health and healing and provides empirical evidence against any assumption that the people in this region advance only spiritual aetiologies of mental illnesses. As the understanding of the conceptualisation of illness is key to achieving therapeutic alliance, the healthcare

professional must recognise the potential for patients in this context to hold strongly mixed and/or even contradictory beliefs about their condition. Trivialising or pathologising clients' beliefs could work against compliance with therapy.

However, the study also found a significantly greater endorsement of the supernatural compared to the biological and psychosocial models by the Nigeria-based sample. These indicate a paradigm shift but in terms of significantly increasing endorsement of the scientific (biopsychosocial) models alongside the supernatural model rather than in terms of significant shift away from the supernatural to the scientific models as suggested in literature (Ohaeri, 1988; Ilechukwu, 1988). The finding of a positive relationship between the endorsement of supernatural causations and the endorsement of psychosocial and biological causations (cf. Chapter five) strongly reinforces this. It is to be envisaged that as Western education deepens and gains wider spread coupled with development in science and technology, there would be corresponding increased awareness of and possible interest in the scientific causal models. This is supported by more recent surveys that suggest a generally greater understanding of the disease basis of mental illness (Penny, 2002). However, some socio-cultural predisposition for the eventual mixed attributions that have been attained could also be envisaged.

A possible explanation for the perseverance of supernatural explanations is the people's deeply religious worldview that shapes the manner in which they conceptualise and respond to experiences including psychopathology. Bhui and colleagues (2002) affirm that the more religious people are, the more they tend to make supernatural attributions. The Igbo people are deeply religious. They not only have strong normative belief in *Chi ukwu* (the Almighty God) who is worshipped and revered as the Supreme Being but also believe in cults of lesser gods, deities and guardian spirits such as *chi* (personal gods) and *ala* (the earth goddess) who enforces morality and punishes taboos with afflictions (Agbodike, 2008). The traditional Igbo society also believes that illness can result from disharmony with one's pre-life accord; one is supposed to live as predestined for him in a prenatal agreement with God just as one is

similarly supposed to be correctly traced to the ancestor who reincarnated in him. Deviations from these arrangements can result in health crisis or pathologic incarnation (ogbanje) - continuous cycle between life and death (Prince, 1975). Furthermore, from the perspective of their Judeo-Christian heritage, the Bible refers to madness and confusion of the mind in terms of consequences of disobeying religious teachings (Kottek, 1992). Loewenthal (1995) explained that the Hebrew term for madness 'Choleh Nefesh' means 'sickness of the soul', resulting from spiritual and moral failings. The suffering is considered to be a warning to the individual to improve their spiritual and moral strength.

The finding that the old contributed significantly more than the young to the endorsement of divine sanction and fate agree with reports from comparative Yoruba culture of south-western Nigeria (Adewuya & Makanjuola, 2008) and depictions in Nollywood - the popular Nigerian movie industry (Aina, 2004; Atilola & Olayiwola, 2011). Arguably, people tend to grow more conservative with age. In the African communalistic culture where the elders are the custodians of traditions and belief systems, the old are more likely to hold enduring pre-scientific and traditional views that may not be easily susceptible to change. The greater endorsement of evil forces by the Protestants compared to the Catholics could be attributed to the consideration that Protestantism is more indigenised in Africa compared to the less independent (Rome-mediated) Catholicism (Meyer, 2004). There is also greater discourse on demonology and activities of evil forces in the Protestant/Pentecostal genre (Haustein, 2011). The finding that females significantly endorsed divine sanction more than males is consistent with the view that females are more religious (Trzebiatowska & Bruce, 2012) and more susceptible to paranormal beliefs (Goode, 2000). Trzebiatowska and Bruce link females' greater religiosity to their leading domestic roles including: involvement in caring activities, greater concern with health and well-being, and greater responsibility for other people's religious commitment and morality. A discrepancy could be observed in more males endorsing supernatural causations than females in the confirmatory study contrary to the

finding in the exploratory study. This variation might be proximately traced to methodology; in the confirmatory study, more females were nurses who were specifically sampled as an occupational group and the study revealed that nurses significantly endorsed supernatural causations less than the non-nursing groups.

The significantly low contribution of nurses to the endorsement of supernatural causations could be linked to the nursing training experience which exposes nurses to conventional mental health knowledge. Such exposure has the potential to moderate the intensity of supernatural causal beliefs as was exemplified in a study of healthcare providers in a related south-southern Nigerian context which found that respondents with high endorsement of the conventional models made low endorsement of supernatural causations (Ewhrujakpor, 2009). The necessity of additionally acquiring some mental health knowledge (besides mere formal education) as the most effective means of disconfirming superstitions and prejudicial beliefs about mental illness has been noted (Mulatu, 1999; Haghighat, 2001). Ballard (1994) had observed that mere formal education does not easily eradicate the more entrenched beliefs of traditional cultures. This conclusion was also reached by Adewuya and Makanjuola (2008) in their study of the comparable Yoruba culture of south-western Nigeria.

Odejide and colleagues (1989) had also found that regardless of level of education, most West Africans in their study continued to adopt supernatural over biological causal explanations of disease. This perhaps explains why the finding in our exploratory study that low education predicted supernatural causal attribution was not confirmed in the substantive confirmatory study. These findings challenge the presumption that formal (Western) education easily eradicates traditional/supernatural beliefs. There is therefore specific need for mental health education. However, it is also possible that nurses' relatively low endorsement of supernatural causations is heightened by a tendency to provide socially desirable responses proper to their position as health professionals.

The higher endorsement of the supernatural model lends credence to the description of African societies as religious in all things with most occurrences interpreted from a religious angle and lens of spirituality. The extent to which these supernatural conceptualisations have positively or negatively impacted on healthcare in African societies and for Africans in diaspora merits further investigation. While the significant endorsement of supernatural causations unarguably reflects the deeply traditional and religious world-view of the people, it is also indicative of the generally very poor mental health literacy reported in Nigeria (Gureje et al., 2005; Audu, Idris, Olisah & Sheikh, 2013).

There is also discernible socio-cultural predisposition for the increasing endorsement of psychosocial causations found in the study. Idemudia (2004) had noted that the aetiology and symptom presentation of the mentally ill are mostly functions of culture. For instance, being a communitarian culture, the Igbo people place emphasis on good moral behaviour and social harmony between an individual and the cosmos in their aetiology of health, believing that breaking of taboos and disruptive behaviours are punishable by ill-health and misfortunes (Nzewi, 1989). The cosmos encompasses one's family, society, peers, ancestors or deities hence the significance of an individual's mental health crisis for the immediate community members and whole ethnic group. In this context, illness can signify conflict and distress in social relationships as Douglas and Fujimoto (1995) had observed. Nzewi (1989) further observed that social harmony is central in Igbo people's diagnoses of mental illness, for instance, in terms of: the degree of beneficial reciprocity - an individual's inability to socialise adequately with neighbours is symptomatic of mental illness; the degree of shame an individual is able to experience (social conformity) - well adjusted individuals experience some measure of shame when they deviate from social norms hence displaying of behaviour which demonstrate complete absence of scruples or shame is indicative of mental illness; being so handicapped that symptoms interfere with fulfilling family responsibilities.

Idemudia (2004) further reported an African belief that diseases or curses can be transmitted

from one generation to another so long as the stains of a fault have not been expiated. There is also the belief that illness can befall a relative for a kin's wrongdoing which somewhat draws a parallel with the theory that defective family interactions could result in psychosocial maladjustment in one member - the scapegoat (Pearce, 1989). Such model of mental health defined in terms of harmony or disharmony between an individual and the wider context has equally been compared to the holistic perspective proposed by Carlson and Shield (1989). Thus, though the African social models are mostly explained spiritually while the West links outcomes to causes through mechanistic and naturalistic models, some convergence is discernible in both viewing illness as signifying distress in social relationships.

Furthermore, some major historical events shaped the psyche of the Igbo people that could have heightened the sense of psychosocial aetiologies of mental illness. For instance, with colonialism and missionary offensive came cultural imperialism that significantly undermined traditional world-views and practices. As the holistic African perspective began to change, the people were faced with the challenge of coping with the two-fold (traditional and euro-Christian) heritage with the attendant conflicts. This was typified in the tragedy of Okonkwo, the tragic-hero in the classic novel *Things fall apart* which articulated the conflicts of the natives with the emergence of the Western colonialists and missionaries. Okonkwo's (Igbo) people were traditionally warriors. However, when Okonkwo returned from unforeseen exile, he could not come to terms with how much the 'white man' had compromised his people who could not rise to the occasion of fighting them back when he (Okonkwo) took the lead. He hung himself in frustration. The encounter with the West therefore brought not only the theory of Western 'scientific' models of psychopathology but also left enduring practical lessons on human vulnerability in the face of conflicts.

Against this background, the Igbo people additionally share a peculiar traumatizing history following their loss to the rest of Nigeria in a civil war. The humanitarian disaster left in the wake of the genocidal war persevered, spiralling an inter-generational transmission of

emotional trauma that has left the people with the scar of a persecuted and deprived minority. Some of the aged un-rehabilitated veterans of that war who still live today as destitute beggars and vagrants serve as constant reminders to successive generations of Igbo people of the damaging effects of conflicts. Kellermann (2001) had suggested that historical links with traumatic experiences influence the personal lives of survivor offspring to be more empathetic to human suffering.

A further predisposing factor for the increased endorsement of the psychosocial model is the observed increasing association of mental illness with abuse of substances and alcohol in this region (Crabb et al., 2012). This may not be unconnected with the increased use of illicit drugs observed among the youths in developing countries (Kabir et. al., 2004). This perception boosts the endorsement of psychosocial causation as confirmed in the finding that abuse of substances/alcohol was the leading causation both in the exploratory (96.6%) and confirmatory studies (96.0%).

Western influence could, in principle, explain the greater endorsement of psychosocial causes by Catholics compared to the Protestants. With its unitary Rome-mediated top-down system, the Catholic Church in the region remains relatively less indigenized and possibly more Western in its ideologies than the other more independent Christian denominations hence the likelihood of greater endorsement of the Western models. The finding that higher education significantly predicted the endorsement of psychosocial causations agrees with the report of Adewuya and Makanjuola (2008) on the comparable Yoruba culture of south-western Nigeria. A study of Ethiopian population also found that education was associated with beliefs in psychosocial stress and biomedical defects models of mental illnesses (Mulatu, 1999). It is to be expected that as formal education in the colonies normally takes after the colonial (Western) models (Mazonde, 2001), the more it is acquired, the more causal attributions will mirror Western models. Moreover, psychiatric practice in Nigeria is significantly influenced by its British colonial history with the majority of

pioneering Nigerian psychiatrists trained in the UK in the 1960s (Ayorinde, Gureje & Lawal, 2004).

The old and those not familiar with persons with mental illness contributed significantly more to the endorsement of personal factors, and in this region these share the common characteristic of having more negative attitudes towards those with mental illness (Ikwuka et al. 2016a). Associating those with mental illness with personal deficits which include negative attributions such as lack of willpower, failure in life and immoral lifestyle could be the grounds for negative attitudes but could also be employed to justify negative attitudes. Furthermore, the old are arguably more conservative and judgmental hence having a greater likelihood of endorsing causations such as personal deficits that indict the individual. Similarly, people who judge from a distant such as those who have no closer knowledge of people with mental illness would more likely be prejudicial - hastily reaching negative conclusions without sufficient information (Penny, 2002). On the contrary, Esterberg and Compton (2006) reported that people who have closer knowledge of people with mental illness such as the relatives of people with schizophrenia e.g. mothers who were primary caretakers of their suffering children are more likely than the general public to endorse biological or constitutional factors in the development of the disorder. While the authors considered that this might be as a result of their associative closer exposure to mental health professionals, they also speculated that it could be coping mechanism that minimizes the guilt they feel at seeing their child suffer since biological causation (which is beyond the individual's control) takes culpability away from individuals. By direct observation, having knowledge of an individual who has received treatment for a mental illness or receiving treatment oneself might also make one informed enough to rule out certain aetiological theories such as immoral lifestyle or faulty up-bringing (Martinez, 2010).

A possible methodological explanation for those not married being significantly more likely to attribute mental illness to psychosocial factors than those that are married is their being

mostly in the younger age bracket which included the majority of the student nurses that generally made greater endorsement of the scientific (biopsychosocial) causal models. Yet, further studies could help unravel any possible relationships between marriage and causal beliefs for mental illness especially in more traditional societies where mental health is very decisive in the prospects of marriage (cf. Chapter two on attitudes towards persons with mental illness). Nurses endorsed psychosocial causal model more than those in the non-nursing professions which could be traced to the peculiar training of nurses which exposes them to both the theoretical knowledge of scientific causal models and experiential knowledge in routine encounters with patients.

Experiences that could inform a predisposition for the increasing endorsement of biological causal factors observed in the study could also be envisaged. For instance, with 2,710 incidents of traumatic brain injury (TBI) per 100,000 population in south-eastern Nigeria (Emejulu, Isiguzo, Agbasoga & Ogbuagu, 2010) compared to 394 in the US (Thurman, 1999) and 453 in the UK (Yates, Williams, Harris, Round & Jenkins, 2006), it is not surprising that brain injury was a leading causation in both the exploratory (93.0%) and the confirmatory (95.8%) studies. Injuries are responsible for an estimated 6% of all years lived with disability with the majority of these occurring in the developing world (WHO, 2014). As Sumaila (2013) rightly observed, accidents with possibilities of disabling injuries are such routine occurrences in Nigeria that only fatalities count. It is therefore a region with high potential for injury-induced disabilities including those from organic brain injury that could easily trigger mental health crises. On the other hand, being a culture highly prone to associative stigma (Ikwuka et al. 2016a), there is high sensitivity regarding possible genetic basis for negative traits which could explain the high endorsement of hereditary as causal factor.

Generally however, the unitary vision of reality in Africa as opposed to the dualistic vision (mind-body disconnect) common in Western thinking means that theoretically, the African world-view is more pragmatic (as the West is more idealistic) thus more primed for biological

attributions. Corroborating this, Jorm (2000) reported on the lay preference for psychosocial stress as a cause of mental illness in the West compared to biological factors. Explaining this tendency, Martinez (2010) suggested that it is possible that psychosocial causes are better understood by the lay Western population than biological theories which might seem more abstract to them. Against this background, Regier and colleagues (1988) had observed that while the general public in the West are more likely to recognise psychological symptoms of a condition (such as depression), the opposite is the case in Africa where description of mood changes are rare while somatisation (bodily descriptions) are common. Psycho-physiological complaints such as depression are often subjectively represented by the African as bodily sensations including: a sensation of heaviness in the brain, a feeling that the belly is bloated with water, heat in the head and body, the sense that the heart is melting and wants to fly away, a sensation of worms crawling all over the body, a lump in the throat or burning sensations in the body (Okhomina & Ebie, 1973).

It could be observed that the leading causations endorsed at the individual causal items level were similar for both the Nigeria and UK based general public sample. However, the order was different; while three scientific causations (abuse of substances/alcohol, brain injury and drug reaction) led for the Nigeria based group followed by 'divine sanction' before 'hereditary' and 'evil forces' in that order, the four conventional causations all came before the supernatural causations for the UK based group. This is a pointer to the more significant finding that the UK based group endorsed supernatural causations relatively less than the Nigeria based group as confirmed by independent samples t-test. From the point of view of methodology, it would immediately appear that level of education which was significantly higher in the UK based group would be a determinant factor for this difference especially given the anecdotal belief that education moderates superstitious beliefs. However, as already observed with the Nigeria based sample, level of education was not a confirmed predictor of supernatural causal attribution. We therefore consider that a more pertinent explanation for

this drop in the endorsement of the supernatural model by the UK based sample is social conditioning (acculturation) which is a more sophisticated tool of change. As Barimah and Teijlingen (2008) had observed, culturally based behaviours change over time towards those prevalent in the host culture. Yet, that there was no significant difference between the two samples in their endorsement of the psychosocial and biological causations underscores the limited effect of acculturation or social conditioning in moderating culturally based beliefs without mediating improved scientific causal knowledge as would be expected. This means that the improvement of the mental health literacy of immigrants with regard to causal beliefs could not be left to the dynamics of social conditioning alone; there is need for a formal system of mental health education.

1.4.1 Conclusion

Mixed attribution is a cheering finding in this study as it demonstrates increased endorsement of the scientific (psychosocial and biological) causal models. On the other hand, it reflects the holistic view of health and healing that could inform therapeutic practice in this context since understanding of causal beliefs and perceptions of illness are keys to achieving therapeutic alliance between the healthcare provider and the patient. Yet, the generally greater endorsement of the supernatural model underscores the significance of the spiritual which permeates the people's world-view including psychopathology. It could also have implication for compliance with and enforcement of the biomedical model of intervention as the classic case of Mr B in the UK's National Health Services (NHS) indicates (Hitchens, 2015).

Mr B, a 73-year old man with mental illness had a life-threatening leg infection. Doctors ruled that amputation was indispensable to save Mr B's life but Mr B declined which could have sufficed legally save for the fact that Mr B lacked 'mental capacity'. The operation would have left him dependent in a nursing home which he detests and he also loathes the prospect of living with the bitter memory of having been compelled to undergo a major surgery against his wish. Mr B declared that he was not afraid to die, that he knew where he was going and

that the angels have told him that he was going to heaven which he considered a better life than the one he presently lives. The NHS Trust argued that Mr B's wishes and feelings and religious belief should be disregarded because they were closely connected with his mental illness. After meeting with Mr B, the judge disagreed with the NHS Trust and granted his plea to refuse amputation.

The judge noted that his religious beliefs are deeply meaningful to him and do not deserve to be described as delusions: they are his faith and they are an intrinsic part of who he is. The judge was enamoured by Mr B's force of personality. After a difficult life marked by loneliness, disappointments and repeated setbacks, Mr B had a fierce independence that could not be ignored. The judge concluded that it would not be in Mr B's interest to take away his little remaining independence and dignity for the sake of a traumatic and uncertain struggle that he and no one else would have to endure. The judge observed moreover that his fortitude in the face of death, however he has come by it, would be the envy of many people in better mental health.

In a related concern, writing on the emergence of Post-Traumatic Stress Disorder (PTSD) as a symptom of a troubled post-modern world, Bracken (2001) a senior research fellow at Bradford University's Department of Health Studies had observed the move away from religious and other belief systems which offered individuals stable pathways through life and meaningful frameworks with which to encounter suffering and death. He noted that the meaningful connections of the social world are consequently rendered fragile.

This study highlighted some variables such as culture, social and historical experiences that possibly disposed the population for the observed attributional patterns. Yet, to make for informed intervention, it would help to determine the extent to which these variables contribute to the patterns of attributions. The demographic groups such as the older in age, the less educated, the Protestants and the females with relatively less likelihood for making psychosocial causal attributions could benefit if enlightened accordingly.

As earlier noted, causal explanatory models have implication for stigmatising views towards persons with mental illness, and influence the symptom presentations of disorders, help-seeking behaviours and recommendations for treatment (Broussard et al., 2010; Muga & Jenkins, 2008; Compton et al., 2006; Carteret, 2011). These themes will be explored in turn in subsequent chapters.

Chapter Two (Study 2)

Attitudes towards Persons with Mental Illness

2.1 Introduction

2.1.1 Theoretical Framework

Attitude is an evaluative disposition towards someone or something (Zimbardo & Leippe, 1991). Attitudes influence behaviour: they serve the dual purpose of guiding behaviour towards various goals and away from adverse outcomes, and they help people to efficiently process complex information about the social world (Baron, 1992). Yet, negative attitudes can be formed without sufficient information i.e. prejudice, thus undermining that critical process of deciphering the world. Stigma is the social devaluation of a person following negative attributions that are based on stereotypes - prejudice based on overgeneralised beliefs (French, 1996 Jones et al., 1984; Pilgrim, 2009). Corrigan and Watson (2002) proposed a stigma concept based on stereotypes, prejudice, and discrimination. While stereotypes represent notions of groups, people who are prejudiced endorse negative stereotypes thereby generating emotional and the consequent behavioural reactions e.g. hatred leading to discriminatory behaviour. The term stigma was originally used by the ancient Greeks to represent the marks that were pricked on slaves to demonstrate ownership and to reflect their inferior social status. The ancient Greek word for prick was 'stig' and the resulting mark, a 'stigma' (Falk, 2001). Stigmatising attitudes towards mental illnesses were already evident at the time as mental illness was associated with concepts of shame, loss of face, and humiliation for instance in Sophocles' *Ajax* and Euripedes' *The Madness of Heracles*. The stigma process consists of two fundamental components: the recognition of the differentiating "mark", and the subsequent devaluation of the bearer (Dovidio, Major & Crocker, 2000).

Sociological theories provide further insight into the dynamics of mental illness stigma. Erving Goffman's (1967) classic formulation relies on two constructs: the actor and the audience. The actor in this context is someone who might have a mental health problem while the rest of the society personified in neighbours, employers, family members, significant others or institutions constitute the audience. Stigma occurs when a person's actual social identity falls short of an ideal identity defined by society, such as behavioural expectations in given situations. Hence, anyone who suffers from a 'gap' between their actual identity and society's ideal identity such as a person with mental illness who may demonstrate lapses in social integration is a potential candidate for stigma. Once spotted, such persons are officially tagged (labelled) which works to isolate them; they are subsequently associated with undesirable characteristics and broadly discriminated against as a result (Corrigan & Penn, 1999; Angermeyer & Matschinger, 2003; Martin, Pescosolido & Tuch, 2000). Attitudes towards the individual change to agree with the label; a 'psycho' is dangerous hence he is kept at a distance. The victim is thus pigeonholed and literally disabled: disempowered, depersonalised and rejected (Pilgrim, 2009). Thus, stigma is not just related to the behaviour sometimes demonstrated by persons with mental illness, but to the label itself. With an experiment where label and aberrant behaviour were manipulated, Link (1987) demonstrated that a person labelled 'mentally ill' is likely to be stigmatised even in the absence of any aberrant behaviour.

A similar finding is reported in the classic Rosenhan (1973) study whereby eight people without mental health problems presented themselves at various mental hospitals, complaining that they had been hearing voices utter the words "empty," "hollow," and "thud". They were quickly diagnosed as suffering from schizophrenia, and all eight were hospitalised. Although the pseudo-patients later dropped all their symptoms and behaved normally, they had great difficulty getting rid of the label and gaining release from the hospital. They reported that staff members were authoritarian in their behaviour towards

patients, spent limited time interacting with them, and responded curtly and uncaringly to questions. In fact, they generally treated patients as though they were non-persons and invisible. One of the pseudo-patients recounts “A nurse unbuttoned her uniform to adjust her brassiere in the presence of an entire ward of viewing men. One did not have the sense that she was being seductive. Rather, she didn’t notice us.” In addition, the pseudo-patients described feeling powerless, bored, tired, and uninterested.

Labelling defines patients in terms of their illness: ‘mental patients’ or ‘the mentally ill’ - terms that evoke images of chronic psychopathology. Furthermore, as Pilgrim (2009) observed, labelling strips victims of their pre-morbid identity and imposes on them the new stigmatised identity and role which comes to define them over and beyond their other roles, for example parenthood or career. A study of terms used by school children for mental illness revealed 250 different words and phrases, none of which are positive (Rose et al., 2007). Scheff (1966) had posited how through the systematic process of labelling and discrimination, the ‘career’ of mental illness is perpetuated for sufferers. These place restrictions on persons with mental illness which confines them to the world defined for them. Discrimination in a range of spheres tacitly constrains them from returning to conventional roles. Consequently, such individuals may be compelled to interpret their experiences in the light of the prevailing social stereotype of mental illness, and even modify their behaviour to fit the image. Thus, once the label is assigned, justified or not, it becomes a self-fulfilling prophecy that promotes the development of many schizophrenic symptoms (Comer, 2015). Below, a survivor of schizophrenia relays this experience:

Like any worthwhile endeavour, becoming a schizophrenic requires a long period of rigorous training. My training for this unique calling began in earnest when I was six years old. At that time my somewhat befuddled mother took me to the University of Washington to be examined by psychiatrists in order to find out what was wrong with me. These psychiatrists told my mother: “We don’t know exactly what is wrong with your son, but whatever it is, it is very serious. We recommend that you have him committed immediately or else he will be completely psychotic within less than a year.” My mother did not have me committed since she realised that such a course of action will be

extremely damaging to me. But after that ominous prophecy my parents began to view and treat me as if I were either insane or at least in the process of becoming that way. Once, when my mother caught me playing with some vile muck I had mixed up – I was seven at the time – she gravely told me, “They have people put away in mental institutions for doing things like that.” Fear was written all over my mother’s face as she told me this The slightest odd behaviour on my part was enough to send my parents into paroxysms of apprehension. My parents’ apprehension in turn made me fear I was going insane My fate had been sealed not by my genes, but by the attitudes, beliefs, and expectations of my parents I find it extremely difficult to condemn my parents for behaving as if I were going insane when the psychiatric authorities told them that this was an absolute certainty (Modrow, 2003, 1- 3).

As individuals so labelled come to accept the label, they could be ‘rewarded’ for affirming the label in regressive behaviour or ‘punished’ if they don’t, even through direct harassment and victimisation (Berzins, Petch, & Atkinson, 2003). The saying that ‘every village needs an idiot and every circus a clown’ could as well have passed as Nigerian where it is common for people to create circuses and oblige the ‘mad man’ to amuse them with his folly (regressive behaviour). As depicted in the Nigerian movie *Village Destroyers*, a common spectacle is a gathering of children and adults around a vagrant with psychosis (‘mad man’) who is obliged to dance weirdly to the mockery tune sang for him. If he does dance, he could be rewarded with something to eat, otherwise he could be punished, denied of the token handouts on which he lives, and often additionally flogged, spat on, kicked about or drenched in waste water.

Skinner and colleagues (1995) note a hierarchy of stigma whereby inferior social statuses like ‘prostitute’ and ‘alcoholic’ are ranked with mental illness at the bottom of the hierarchy. The stigma of mental illness has been referred to as the ‘ultimate stigma’ (Falk, 2001). It exceeds those of other conditions and stigmatised groups including foreigners, immigrants, individuals with AIDS and those with physical disabilities because the public perceives it as most disabling (Economou, Gramandani, Richardson & Stefanis, 2005; Thompson et al., 2002). By a process of association and class identity, all mental patients are stigmatized (Arboleda-Flórez, 2001). The individual patient, regardless of level of

impairment or disability, is lumped together into a class. Belonging to this class reinforces the stigma against the individual as the stigmatised person is viewed stereotypically as a model of social group rather than an individual. However, of the specific disorders that have been investigated, people with psychotic disorders or substance misuse have been the most stigmatized (Rao et al., 2009; Griffiths et al., 2006) and their care underfunded (Braff, 1992). Those with schizophrenia are more likely to additionally experience physical and verbal attacks (Dinos et al., 2004). Torrey (1995) suggests that schizophrenia is the modern-day equivalent of leprosy as there is no other disease in the Western world that confers such social ostracism on the people afflicted and on their families.

2.1.2 Stigma Typologies

2.1.2.1 Public Stigma

To be marked as 'mentally ill' carries public, internal (self) and associative stigma. Public stigma occurs when the general population endorses stereotypes and decides to discriminate against people labelled 'mentally ill' (Corrigan, Druss & Perlick, 2014). It is mostly caused by the stereotypes of people with mental illness as unpredictable, violent, deranged, incompetent or retarded (Atilola & Olayiwola, 2011; Jorm & Griffiths, 2008; Marie & Miles, 2008). With the stereotype of dangerousness and unpredictability, fear becomes the primary impulse to the development of stigma. Hence, Foucault (1978) had suggested that the strongest cultural stereotype of persons with mental illness focuses on the spectre of a homicidal madman - a deranged being who explodes violently, erratically and inexplicably. These stereotypes could also suggest that persons with mental illness are incapable of normal human activity. Aside the stereotype of dangerousness endorsed by 88% of the respondents, a study by the Canadian Mental Health Association (1994) found the most prevalent misconceptions about persons with mental illness to include that: they had a low IQ or were developmentally handicapped (40%), that they could not function, hold a job, or had anything to contribute (32%) and that they lacked the will power

or were weak or lazy (24%). This echoes the finding from the pilot study for the World Psychiatric Association (WPA) Programme “Open the Doors” (Stuart & Arboleda-Florez, 2001a) where 72% of the respondents believed that persons with schizophrenia could not work in regular jobs. Arboleda-Flórez (2001) reports of Michelle, a vivacious 25 year-old office worker who tells about her major disappointment with her family and family friends that simply expected her to have an abortion when she announced that she was pregnant. They assumed that her schizophrenia would incapacitate her to deliver and to care for her baby. They were also afraid that her medications could have teratogenic effects on the baby. She carried her baby to term and is taking care of it despite the opposition of family and friends.

2.1.2.2 Self-stigma

Attitudes toward people with mental illness also have implication for the perceptions they hold about themselves. Self-stigma occurs when persons with mental illness internalise the corresponding prejudice; in acquiescing to the negative profile imposed on them, sufferers become prejudiced towards themselves. It can lead to low self-esteem (Byrne 2001; Ritsher & Phelan, 2004), self-loathing (Larson & Corrigan, 2008), avoidance of social activities (Perlick et al., 2001), depression (Leff & Warner, 2006), a sense of shame, fear and loneliness (Granerud & Severinsson, 2006) which ultimately result in low quality of life. Patients may become captive in their homes because of other villagers’ twitching curtains, whispering about them and cold-shouldering (Crawford & Brown, 2002). It could lead to concealment of psychiatric conditions, living in denial of symptoms, and fear and discouragement from promptly seeking appropriate treatment (Kahng & Mowbray, 2004; Kiefer, 2001). Thus, self-stigma is a major obstacle to the recovery of those with mental illness (Ritsher, Otilingam, & Grajales, 2003).

In addition to not receiving treatment or support, those who hide concealable stigmas may face considerable stressors and psychological challenges in keeping the stigma secret (Pachankis, 2007). Furthermore, because mental health difficulties are often not

obvious to the casual observer, the sufferer may be very wary of anything that might give them away (Kermode et al., 2009). They are thus in perpetual conflict. Moreover, if their status inadvertently comes to the fore, for instance through crisis, they subsequently face the arduous task of perpetually ‘mending face’ (Goffman, 1967). Living with such an unsettling internal state, they are less likely to be successful in work, housing, and relationships (Link et al., 1989). In some traditional collectivist cultures, it could lead to defensive (situational) causal attribution for the condition by the sufferer and their family. For instance, they could start purporting that the condition is the handiwork of supernatural forces, or evildoers (Aghukwa, 2009a) which will in turn lead to rejection or discontinuation of orthodox care and seeking help from religious and traditional healers. Thus, self-stigma compounds the effects of stigmatisation. It is considered the most damaging aspect of stigma as internalisation of the stigmatised status could lead mental health service users to believe that they are of less value (Green et al., 2003), incapable of working and independent living (Corrigan & Penn, 1999).

One in four psychiatric patients in Nigeria have experienced high self stigma (Adewuya, Owoeye, Erinfolami & Ola, 2011). In *The Last Taboo* (Simmie & Nunes, 2001), one of the authors describes his feelings after a bout of major depression: “Stigma was, for me, the most agonizing aspect of my disorder. It cost friendships, career opportunities, and – most importantly – my self-esteem. It wasn’t long before I began internalizing the attitudes of others, viewing myself as a lesser person. Many of those long days in bed during the depression were spent thinking, ‘I’m mentally ill. I’m a manic-depressive. I’m not the same anymore’. I wondered, desperately, if I would ever again work, ever again be ‘normal’. It was a god awful feeling that contributed immensely to the suicidal yearnings that invaded my thoughts.” Exaggerated pessimistic attitudes about prognosis may increase self-stigmatization which could lead to evasion of help-seeking (Björkman, Angelman & Jönsson, 2008; Corrigan et al., 2014).

2.1.2.3 Associative Stigma

Stigma impacts beyond the individual sufferer as relatives could become victims of "courtesy-stigma" (Angermeyer, Schulze & Dietrich, 2003) - being stigmatized because of their association with someone with mental illness. Families report lowered self-esteem and strained relationships with other family members because of stigma (Gray, 2001; Van der Sanden, Bos, Stutterheim, Pryor, & Kok, 2013). Half of the families surveyed by Phelan and colleagues (1998) in the Suffolk County of New York had concealed their relative's hospitalization from others because of the fear of social rejection. Associative stigma is more widely felt in communitarian cultures because the family represents the centre of the social institution; the burden of the stigma rests more with the family rather than on the individual (Adler, & Mukheji, 1995). While emotions such as pride and shame relate to how personal behaviour reflects on the self in individualistic cultures, they relate mainly to how personal behaviour reflects on others in collectivist cultures (Mesquita, 2001). To protect the integrity of their kinship system and group identity, communitarian cultures may be led to distance themselves from the person with mental illness (Tyler et al., 2008; Abdullah & Brown, 2011). Stigma therefore seems to be a prominent barrier to care seeking in these cultures (Alvidrez, Snowden, & Kaiser, 2008; Conner, Koeske, & Brown, 2009; Mishra et al., 2009).

Over 50% of respondents in a study of the attitudes of 160 Yemeni men justified their reasons for not having a relationship with someone with a mental disability based on the fear that they would be viewed negatively by their peers (Alzubaidi, Baluch & Moafi, 1995). Collectivist aspects of some Asian groups, may, for example, lead to perceptions that disabilities of mental illness reflect flaws of the family (Lauber & Rössler, 2007; Sanchez & Gaw, 2007). Shame is worsened when disabilities suggest lack of conformity to social norms, a Confucian ideal (Kim, Atkinson, & Yang, 1999; Lam,

Tsang, Chan, & Corrigan, 2006). As a result, Asians who endorse stigma are less likely to seek services when in need (Miville & Constantine, 2007; Shea & Yeh, 2008).

If a history of mental illness is found in either a potential marriage partner or one of their family members in Nigeria, marriage would generally not proceed. A man whose wife suffers from schizophrenia recalls how mental illness still attracts shame to many families in Nigeria “My wife’s mental illness started after the birth of our fourth child in 1993, at first I thought it was high fever but it degenerated to the point of her making trouble with everybody in the neighbourhood and going nude at times. It has been hard for us, especially me, the husband, because of the costs, work and shame that I have to bear” (Eaton & Tilly-Gyado as cited in Ewruhjakpor, 2010b, pg. 139). A teacher in Maiduguri, north-eastern Nigeria, vowed that she would never allow any of her offspring to specialize in psychiatry nor marry a psychiatrist because of the age-long cultural belief among the Kanuri people that anyone treating persons with mental illness would likely have one of their offspring suffer from mental ailment (Oyegbile, 2009). Yet, some degree of associative stigma could be observed in individualistic (Western) cultures. Reporting from Canada, Arboleda-Flórez (2001) tells the story of John, a 19-year-old university student, who had to accept the termination of a relationship he had just started with a girl from his neighbourhood. Her parents objected to the relationship and decided to send her to another city for her education partly in an attempt to break up the relationship once they knew that John’s mother’s frequent hospitalizations for the past several years were not due to “diabetes”, but to a manic depressive illness. John described the experience with some resignation, “it seems as if I have to carry the sins of my parents”. Some family members and friends can also experience vicarious stigma - the sense of sadness and helplessness a family member feels when observing a relative being the object of prejudice or discrimination because of mental illness (Corrigan & Miller, 2004).

By association, mental health practice and practitioners could also be stigmatised (Persaud, 2000). A comprehensive review of more than 500 studies showed that the public endorses varied stereotypes about psychiatry and psychiatrists (Sartorius et al., 2010). Psychiatrists were perceived to represent “the end of the line” and were associated with “mad” people or “asylums” (Youssef & Deane, 2006). There is anecdotal belief that psychiatrists tend to behave like their clients. Medical students believe that psychiatrists “must be crazy”. They view psychiatric practise as having low status, the public view it as ineffective or possibly harmful, patients view it as failing to target essential problems, and the media view it as a discipline without true scholarship (Corrigna et al., 2014). Psychiatrists are often stereotypically portrayed in the media as libidinous lechers, eccentric buffoons, vindictive, repressive agents of society, or evil minded, and in the case of female psychiatrists, as loveless and unfulfilled women (Gabbard & Gabbard, 1992). Psychiatrists and psychologists are not highly respected or appreciated and do not have the same elevated status as medical practitioners because they work with people with mental illness (Wellington, 1992). The theory of cognitive dissonance (Festinger, 1957) suggests that given a choice, health care professionals would tend to select careers in areas where they hold favourable attitudes. Student psychiatric nurses reported disappointment from their family members on their choice of specialization (Wells, McElwee & Ryan 2000). Yet, antipathy to psychiatry or to its practitioners directly undermines participation in fundamental services the profession provides.

2.1.3 Stigma Causal Factors

Aside stereotypes and labelling, other factors that engender or reinforce stigmatising attitudes as discussed below include: culture (Kermode et al., 2009; Al-krenawi et al., 2009), nature and symptom presentation of illness (Dietrich et al., 2004; Hugo, 2001), diagnosis of mental illness (Meltzer et al., 2000; Crabb, et al., 2012) and psychiatric hospitalisation (Rao et al., 2009; Link et al., 2004). Others are: explanatory models of causation (Grausgruber et al., 2007; Jorm & Griffiths, 2008), pessimism regarding prognosis (Aghukwa, 2009a; Paterson 2006), media

(mis)representations (Dietrich, 2006; Dinos et al. 2004) and negative government policies (Corrigan & Watson, 2003; Okpi, 2013).

2.1.3.1 Culture

Cultural norms and perceptions determine social indicators of mental illness thereby impacting stigmatizing cues (Abdullah & Brown, 2011). Culture provides its members with available repertoire of affective and behavioural responses to the human condition, including illness; it offers models of how people should or might feel and act in response to the serious mental illness of a loved one (Jenkins & Karno, 1992). Dohrenwend (1966) had contended half a century ago that ethnically based cultural norms could well shape perceptions of the social undesirability of psychiatric symptoms. The prevailing beliefs which shape people's notion of mental illness include stereotypes as well as the climate in which these stereotypes are endorsed (Corrigan, Druss, & Perlick, 2014). Stigma attached to psychiatric services may also be influenced by traditional health belief systems, issues of shame, and the perception of instability affixed to individuals seeking outside assistance (Gellis, Huh, Lee & Kim, 2003). As people tend to hold strong beliefs about mental illness (Asuni, Schoenberg & Swift, 1994), if cultural beliefs surrounding psychiatry are negative, the attitudes of people towards sufferers will remain largely negative (Kermode et al., 2009; Al-Krenawi et al., 2009).

Negative perception of and attitudes towards people with mental illness in Nigeria is partly linked to deeply rooted negative cultural beliefs that see mental illness as a deviation from normality and retribution for evil with persons with mental illness needing to be quarantined (Ewhrudjakpor, 2009; Kabir et. al., 2004). Triandis (1989) noted that in individualistic (Western) cultures, behaviour is often determined by personal goals while in collectivist cultures, in-group goals are given greater salience resulting in the possibility of stronger spread of negative attitudes with families more likely electing to keep secret the existence of a member with a disability or mental illness. This agrees with the suggestion that

gregariousness fosters gossip and provincial attitudes of interference with intimate problems in a closed and centralized system (Levav et al., 2004; Papadopoulos, Leavey & Vincent, 2002). Studying suicides in the Indian context, Gehlot and Nathawat (1983) found that a large number of cases could be explained by 'performance' failures which refers to the fact that when individuals fail to 'perform' or live up to expectations imposed by family and society as a whole, they experience shame, have a fear of social stigma, with fears of having let the family/community down. As Pearce (1989) observes, aspects of group life can become noxious for an individual who finds a situation stressful as a result of them. The degree of stigma also varies with regional and residential attributes, for instance, while epilepsy is a taboo in Africa (Grunitzky, Balogou & Dodzro, 2000) it is less stigmatised in the West (Baker, 2002).

2.1.3.2 Nature and Symptom Presentation of Illness

People could also hold attitudes based on what they have experienced of the attitude object (Hugo, 2001). Hence, a major determinant of stigma is the behaviour of the person with mental illness and the associated disability (Jorm & Griffiths, 2008). Illnesses that present in serious observable deformities or lesions like leprosy or in extremely bizarre psychotic behaviours such as schizophrenia are the most negatively perceived (Mulatu, 1999; Marie & Miles, 2008; Al-krenawi et al., 2009). This would be reinforced in the Nigerian context where symptoms of mental illness are mostly judged on behavioural grounds (Binitie, 1970). Hence, most manifest deviant behaviours attract mental illness labels and equate to psychiatric illness presentation in the involved person. Sometimes persons with a serious mental illness such as schizophrenia also suffer negative symptoms like alogia (poverty of speech), anhedonia (poverty of affect), avolition, and catatonia (motor abnormalities). These can constitute serious hindrance to interaction with others and integration into the society. Bell and colleagues (2008) report that more than half of pharmacy students in a cross-cultural study thought that patients with schizophrenia and severe depression were difficult to talk

with which may contribute to their receiving less medication counselling than patients with physical health disorders.

There are also positive symptoms like disruptiveness mainly from patients suffering paranoid schizophrenia which could lead to the stereotype of dangerousness and unpredictability. Hugo (2001) observed that the majority of mental health professionals' negative attitudes are informed by their experiences with people with mental health problems many of which would be when the clients are in crisis situation. Two-thirds of nurses reported verbal or physical abuse in an Australian survey (Australian Nurses Federation, 2003). Fearing aggression, health care professionals that had faced violent experiences from persons with mental illness could develop a negative and avoidant attitude towards persons with mental illness which could lead to a biased view of consumers' potential. Penn and colleagues (1994) observed that the notion of previous symptomatology in the acute phase of schizophrenia was more stigmatizing than a label alone. It may reinforce the stereotype of the recovered patient as unstable and if the recovered person fails to deter the spread of such information, they may face rejection, even if presenting with non-aberrant behaviour. It is against such backdrop that Wallach (2004) noted that such brief exposures during the acute phase can be detrimental and can lead to increased social restrictiveness.

2.1.3.3 Diagnosis of Mental Illness/Psychiatric Hospitalisation

The complexity of stigma dynamics is such that diagnosis of mental illness and psychiatric hospitalisation in themselves could stigmatise (Rao et al., 2009; Crabb et al., 2012). Torrey (1994) had suggested that the stigma associated with diagnosis is worse than dealing with the mental health problem itself. Similarly, the stigma that attends to accessing care for mental health problems has been considered to be a greater barrier to seeking help than the stigma attached to the condition itself (Rost, Smith & Taylor, 1993). Meltzer and colleagues (2000) had noted that openly discussing one's problems with mental health professionals can

attract shame which could even lead to some patients being suicidal. Patients try to contend with these through rejection of the psychiatric explanation of their problems (Sayre, 2000). Although well intentioned in its origins, the asylum mentality that saw to the sectioning of those with mental illness in far away mental hospitals contributed to social distance from them. It structurally helped to define them as different and led to their dislocation from their communities, loss of their community ties, friendships and families. At a more systemic and academic level, institutionalisation meant the banishment of mental illness and psychiatry from the general stream of medicine which helped to reinforce the idea that such patients were incurable (Arboleda-Flórez, 2001).

2.1.3.4 Causal Explanation for Mental Illness

Attribution theories underscore the importance of the causal beliefs people hold for a characteristic or behaviour in determining their responses to the person displaying the characteristic or behaviour (Bag, Yilmaz & Kirpinar, 2006; Jorm & Griffiths, 2008). Research generally reveals an interaction of culture and causal explanations in shaping attitudes towards people with mental illness. For instance, in India, reduced social distance for both depression and psychosis was consistently associated with belief that the problems are caused by personal weakness (Kemodé et al., 2009). In contrast, positive association between social distance and viewing mental disorders as a sign of personal weakness has been found in surveys in a number of Western countries including: Australia (Jorm & Griffiths, 2008), US (Martin, Pescosolido, Olafsdottir & McLeod, 2007), the Netherlands (van't Veer, Kraan, Drosseart & Modde, 2006) and Austria (Grausgruber et al., 2007). While the majority of studies of Western population in a review by Jorm and Oh (2009) indicated negative association between the adoption of childhood adversity/social stressors (psychodynamic) causal explanations and social distance, a study of Turkish population (Ozmen et al, 2004) found a positive association. Furthermore, while all the studies of Western populations in the review by Jorm and Oh (2009) found positive association between biogenetic causal

explanation and social distance, America (Martin, Pescosolido, Olafsdottir & McLeod, 2007) and the Netherlands (van't Veer, Kraan, Drosseart & Modde, 2006) were two exceptions. Further fuelling negative attitude is the pervasive pessimism of prognosis that sees mental illness as incurable (Botha et al. 2006; Paterson 2006; Aghukwa 2009a; Youssef & Deane, 2006). Many Nigerians believe that mental illness is incurable and terminal (Ewhrudjakpor, 2009).

2.1.3.5 Media (Mis)representation of Mental Illness

The grotesque and sensationalistic portrayal of persons with mental illness in the media and in the movies right from the beginning of the industry in the early 1900s is a major source of negative attitudes. Research into the portrayal of mental illness in the media around the world has generally found that negative depictions predominate (Francis, Pirkis, Dunt & Blood, 2001). Wahl and Harman (1989) found that 85.6% of relatives of persons with mental illness identified movies about “mentally ill killers” as the most important contributor to the stigma of the illness. Two mass communication theories: cultivation theory and social cognitive theory (Stout, Villegas & Jennings, 2004) provide the mechanisms by which the media influences mental illness stigma. The theories describe how the construction and perpetuation of mental illness stigma occur through the media’s social construction of reality. While cultivation theory proposes that repeated exposure to consistent media messages shapes values and perceptions of reality to fit those presented in the media, social cognitive theory on the other hand proposes that, in addition to direct experience, individuals vicariously learn about appropriate behaviour and affective reactions through observation, particularly from media sources.

Common media depictions of persons with mental illness include being dangerous to others, involved with crime, vulnerable and unpredictable. Such depictions stem from sensational reporting of crimes purportedly committed by someone with a mental illness, or from movies in which a popular plot, long exploited by the cinematographic industry, is that

of the “psycho- killer” (Byrne, 1998). Characters with mental illness are portrayed in prime time TV shows as rebellious homicidal maniacs with childlike perceptions of the world. They are projected as free spirits that lacked social identity, usually single, unemployed and described negatively with adjectives such as “aggressive” “confused” and “unpredictable” (Wahl, 1995; Farina, 1998). Media misrepresentations of mental illness including in children’s cartoons and in the language employed to deplore misbehaving politicians or public officers can cause, fuel and perpetuate both public and self-stigma (Brown & Crawford, 2002; Seff, 2003; Wahl, 2003; Dietrich et al., 2006). Since much of the public image of severe mental illness is informed by the mass media (Torrey 1994; Wahl 1995), the type of information provided by the media will be crucial in forming attitudes. Disturbingly however, media depiction of mental illness and persons with mental illness are typically inaccurate and overwhelmingly negative (Alexander & Link, 2003; Wahl, 1992).

When the rare, but tragic events associated with someone having one of the serious mental disorders is sensationalised by the media, they amplify fear while the more important millions of people who live full, productive lives with these disorders are underrepresented. Media portrayals fail to indicate that the percentage of violence that could be attributed to mental illness as a portion of the general violence in the community is small (Monahan, 2009) and they have far less coverage of positive issues such as accomplishments or human rights issues (Coverdate, Naim, & Classen, 2001; Edney, 2004). Duckworth and colleagues (2003) randomly selected 1,740 American newspaper articles that mentioned schizophrenia or cancer between 1996 and 1997 and found that while only 1% of the articles cited cancer in an inaccurate metaphorical sense, there were 28% of such inaccurate citations for schizophrenia.

Mehta and colleagues (2009) observed that public attitudes towards people with mental illness deteriorated during 1994 – 2003 in Britain but especially in England and this situation was linked to the effect of adverse media reporting which took place over the time when changes to the Mental Health Act were being widely debated and often reported in relation

to the risk of violence posed by people with mental illness. The relatively more positive outlook in Scotland was linked to the early effect of the 'see me' campaign that was launched in Scotland in 2000. There appears to be an unquestioning acceptance in the British media of the 'rising toll of killings' as a result of community care for persons with mental illness. For instance, following the murder of Margaret Muller, an American woman found dead while jogging in Victoria Park in East London, the Daily Mail (21 February, 2003) published the headline '400 care-in-the-community patients living by murder park'. On discovering that a large number of care-in-the-community patients lived near the park, the police and the media automatically assumed that the victim was 'murdered by a deranged psychiatric patient living in the community.'

On the 23rd of September 2003, the former world heavyweight boxing champion Frank Bruno was admitted to a mental health unit in Essex. The Sun newspaper published a breaking news headline 'Bonkers Bruno Locked Up' that provoked national outcry which forced the Sun to retract the headline. Suggestive headlines like this are pervasive as the print media consistently present the image of the dangerous, unstable, incurable mental patient. It is not uncommon in Britain to read the labels 'maniacs', 'schizos', 'psychos', and 'nutters' in the tabloid newspapers when stories are published about people with mental health problems. Even the traditionally more conventional broadsheet newspapers in the UK overwhelmingly tend to endorse this stereotype of people with mental illness as being potentially harmful to others, both in fictional and non-fictional representations (Philo, 1996). A study found that people's attitudes towards those with mental illness markedly worsened directly after media reports of two violent attacks on prominent politicians by two persons with mental illness (Angermeyer & Schulze, 2001).

Though the association between mental illness and violence, specifically schizophrenia is confirmed epidemiologically (Arboleda-Florez, 1998), this seems to flow not so much

through direct links of causality, but through a series of confounders such as co-morbid substance use and abuse (Davis, Uezato, Newell, & Frazier, 2008; Drake et al., 2006). Unfortunately, one single case of violence is usually enough to undermine whatever gains patients with mental illness have made to be accepted back into the community. Even when reported conscientiously and accurately, this type of news provokes fear and apprehension and pushes the public to demand measures to prevent further crimes. Consequently, persons with mental illness in general bear the brunt of impact as they are stereotyped because of the actions of the few.

2.1.3.6 Negative Policies

Specific policy measures may fuel already fearful and intolerant public attitudes towards people with mental illness (Wells, 1998; Corrigan & Watson, 2003; Okpi, 2013). For instance, in response to high-profile but isolated incidents in which vulnerable people with mental health problems have taken the lives of others, there was a suggestion that the UK government considered a review of community mental health care apparently to ‘maintain the safety of the public’ (Thomson & Sylvester, 1998). More of such policy measures will be highlighted when we discuss the pervasiveness of stigma (section 2.1.5).

2.1.4 Consequences of Negative Attitudes toward Mental Illness

2.1.4.1 Social Exclusion

Stigma has the potential to impact on all aspects of life (Schulze et al., 2003). It begets social exclusion which deprives people with mental illness of their basic citizenship rights, happiness and sharing in the ‘commonwealth’ of life (WHO, 2001b; Pilgrim, 2005). It strips people of their dignity and represents a major barrier to effective rehabilitation and reintegration of people with mental illness. Forty years since the beginning of the era of deinstitutionalization, people with Serious and Persistent Mental Illness (SPMI) are still not well integrated into the society (Moldovan, 2007). Stigma can rob people with mental illness of opportunities for obtaining competitive employment, accessing of services and

living independently in a safe and comfortable home (Corrigan et al., 2005; Link & Phelan, 2006; Stuart 2006). Hence, stigmatising attitude of the general public but especially of members of key groups such as employers, landlords and primary care physicians can be especially poignant in the lives of people with mental illness.

Sayce and Boradman (2003) note that a major difficulty with rehabilitation in mental disorder is convincing members of the community such as employers or landlords that people can and do recover from mental illness. A total of 69% of people living with a long-term mental illness in the UK reported that they had been put off applying for jobs because of unfair treatment and a similar percentage felt that they had been unfairly treated by family and friends because of their illness. Only 21% of this group are working, and of these, only 13% are actually employed - the lower percentage working than for any other group with long-term illness or impairments (Office of National Statistics, 1995). This corroborates Pilgrim's (2005) submission that people with mental illness are three times more likely to be unemployed than those with physical disabilities which has more to do with the attitude of employers than lack of willingness on the part of the individual as indicated by the Citizens Advice Bureau CAB, UK (2003). The CAB equally reported that most people with mental illness are unemployed and those who have jobs end up leaving because their employers convince them that they are unable to cope.

In a study by Dunn (1991), Jo, a mental health service user relayed her experiences at work. When she told her boss that she had to see a psychiatrist 'his reaction said it all, as soon as mental illness is mentioned people literally back away from you' p.3. Thus, people with mental illness can fear losing their job where they are employed. Some believe that they were dismissed or denied employment because of their condition (Putman, 2008). At the work place, employees with mental illness note that colleagues could be unsupportive, making snide remarks and feeling that they should do more to 'make up' for the fact that they had an illness (Warner, 2002). They can be advised to lower their expectations for a productive

life and denied insurance coverage (Wahl, 1999; Björkman et al., 2008). Social exclusion is thus a complicated and often cyclical process; limited access to one service can have a knock on effect on others. For instance, restricted use of education and training opportunities can sustain unemployment leading to more dependency on benefit which deepens a person's exclusion, causing further decline in their health and quality of life.

The World Health Organisation highlights the pervasive role of mental health stigma in society with regard to suffering, disability, poverty, alcohol misuse, drug abuse, homelessness or excessive institutionalisation (WHO, 2001b). Stigmatisation also damages inter-personal relationships including friendships, marriage and family relations (Wahl & Harman, 1989; Kermode et al., 2009; Fabrega, 2001; Kung, 2003). Discrimination is evident in every area of life particularly for those suffering with psychosis and drug dependence (Rao et al., 2009). In a study by Brown and Crawford (2002), a patient with schizophrenia shares her telling experience whereby her actions (which should normally have been considered on their merit) were interpreted from the perspective of her mental illness. '... [S]o you're sat at home on high tranquillisers. [Laughter] You try and go out up the club for a drink, and you have one drink with your medication and you're sat in the pub like this. [Laughter] I think everyone thought I was a junky ... Because I'd go in the pub and have one drink, and I'd be all floaty and happy. And they'd say, 'Hey, she is off her head.' It is very hard to live with it especially in a small community, because everyone else knows everyone else's business. This submission also underscores the observation that there is lack of confidentiality and possibility of interference with intimate problems in small closed systems (Levav et al., 2004; Papadopoulos, Leavey & Vincent, 2002). Institutional stigmatization can equally occur whereby the idea that 'mad people' are also being treated in the community facility is abhorrent to some people such as people living in the neighbourhood and some health staff (Gater et al., 2005).

2.1.4.2 Structural Discrimination

Some inequities represented by system-level barriers are attributed to structural stigma - process that represents policies of private and governmental institution that intentionally or unintentionally restrict opportunities of people with mental illness (Link & Phelan, 2001). An example of intentional institutional discrimination is state legislation that limits the civil rights of people with mental illness. Studies examining state legislation in the 1980s (Burton, 1990) and 1990s (Hemmens et al., 2002) indicated that as many as 20 states in the US restricted voting, jury duty, elective office, parenting, and marriage rights because of mental illness. Some of the restrictions are informed by the stigmatizing beliefs that people with mental illness are not capable of being full citizens or family members (Pelletier, Davidson, Roelandt, & Daumerie, 2009). On the other hand, research has shown that endorsing stigma is inversely related to resource allocation. People who endorsed the idea that people are to blame for their mental illness were less likely to provide more money to mental health programmes in a government-fund allocation task (Corrigan, Watson, Warpinski, & Gracia, 2004). Attitudes also influence policy decisions regarding the persons with mental illness in terms of their rights (Levey & Howells, 1994) and planning of psychiatric services (Mino, Koderá & Bebbington, 1990). Legislators who endorse stereotypes of persons with mental illness can block funding for mental health services that may promote independent living and recovery goals (Corrigan et al., 2004).

In the Report on Mental Health issued by the US Surgeon General, the stigma of mental illness was noted for reduced levels of service funding (U.S. Public Health Service, 1999). In spite of being a leading cause of disability, it is observed that mental health receives the least funding in the health budgets of many developing countries. Often, less than 1 per cent of expenditure on health is made on services for psychiatric conditions in African countries (Kleinman, 2009). High premium is placed on infectious disease and maternal and

child health as evidenced by high budgetary allocations to these sectors in comparison to mental health services (Ayorinde & Gureje, 2004; Gureje, 2003). Relative to other illnesses, schizophrenia receives low levels of funding for research and treatment facilities for schizophrenia tend to be located in isolated settings or disadvantaged neighbourhoods (Link et al., 2004). In Canada, for instance, mental health research commands less than 5% of all the health research budgets, yet mental illness directly affects 20% of Canadians (Canadian Alliance on Mental Illness and Mental Health, 2000).

People with mental disorders are more likely to be uninsured or underinsured than the general population (Garfield, Zuvekas, Lave, & Donohue, 2011). Health insurance companies openly discriminate against persons who acknowledge that they have had a mental health problem. Life insurance companies, as well as income protection insurance policies make an ordeal out of collecting payments due to temporary disability caused by mental health conditions such as anxiety or depression with many patients seeing their payments denied or their policies discontinued (Arboleda-Flórez, 2001). When structural stigma such as insurance barriers and inadequate systems of community support persist, effective efforts to prevent or treat mental illness is stalled leading to negative socio-economic consequences such as the loss of productive workforce. Structural discrimination can also take place with regard to legal provision as well as the interpretation and administration of laws (Gutierrez-Lobos, 2002). Criminalisation of mental illness occurs when people with mental health problems are dealt with by the police, courts and jails, instead of the mental health system (Watson, Corrigan & Ottati, 2004). Persons with mental illness are more likely to be accused falsely of violent crimes (Sosowsky, 1980; Steadman, 1981) leading to their higher arrest rates (Goodman, 1992; Raymond, 1991). People with mental health problems also spend more time in incarceration compared with 'normal' people (Steadman, McCarty & Morrissey, 1989). Though nearly half of service users had been verbally or physically harassed in public because of their mental illness (Read & Baker, 1996), many could be

denied justice should they seek redress as they are often not seen as credible witnesses and prosecutions are frequently dropped (Women against rape/legal action for women, 1995). A leading Nigerian newspaper *The Punch* recently reported an incident where a young man sexually violated female inmates of a mental health rehabilitation centre in Lagos state. The young man was charged to court but the prosecution could not proffer rape charges against him 'due to the mental health status of the victims'. A case of breaching public peace was rather preferred (Adesomoju, 2013).

2.1.4.3. Burden of disease

Stigma results in both short and long-term personal distress for affected people. It can have significant negative impact on the psychosocial functioning of people with mental illnesses through both experienced and anticipated discrimination. Stigma consciousness (anticipated stigma) is where individuals fear being categorised within a stigmatised group because they are perceived as carrying certain traits, for instance, they fear being labelled 'mentally ill' which is socially stigmatised (Pinel, 1999). In the absence of overt discrimination, they may anticipate stigmatizing responses at work and in relationships and become preoccupied with concealing their status. This could exacerbate paranoid symptoms for people with serious mental illness such as schizophrenia. Perceived stigma likely leads to significant loss of self-esteem and self-efficacy, depression, limiting of social and occupational functioning, withdrawal and reduced trust in others (Link et al., 2001; Perlick et al., 2001; Markowitz, 1998). It can also affect psychiatric treatment adherence (Sirey et al. 2001). Stigma can generate emotional feeling of fear, anxiety, anger, hurt, sadness, discouragement, isolation, guilt and embarrassment (Dinos et al., 2004; Wahl, 1999). It may increase the environmental stress of persons with mental illness and decrease their ability to cope (Link, 1982). People with mental health problems can also experience extreme of negative attitude such as direct harassment and victimisation (Kelly & McKenna, 1997; Berzins et al, 2003).

Neglected by inept system and abandoned by overwhelmed families, the home of many persons with serious mental disorders in Nigeria is on the streets and in open market squares where they eat from waste bins and are exposed to the extremes of weather without shelter. Ironically, the negligent society has a supposed 'wisdom' in a proverb which holds that 'once madness (a mad person) strays into the market square, it cannot be cured'. This literally presumes the presence of some mysterious force in the market square that exacerbates mental illness thus making it irremediable when in actual fact, the exposure to the elements is more likely to exacerbate mental illness. Almost half of service users surveyed by Read and Baker (1996) had been verbally or physically harassed in public because of their mental illness. In the study by Brown and Crawford (2002), a patient with schizophrenia recounts the ordeal of labelling 'I came back from the toilet once and this bloke making a nice comment about how I looked. Then this other bloke went, 'Oh no, she's a nutter, you don't want to go there!' and I heard them say it, and I said, 'Oh, I'm a nutter am I?' I said. 'Well, how come I can have a serious conversation with you then?' I've done this, I've done that. I really pointed him up on it, what it was really like to be labelled a nutter. He was so sorry afterwards, and he comes over and talks to me now. It's the fear of the unknown. Once you get a label.' Fear of the unknown depicts the high vulnerability of persons with mental illness to maltreatment following labelling.

Granted that stigma makes some people with mental illness more determined to succeed, the negative impacts can be overwhelming and can persist despite psychiatric treatment and recovery from mental illness. Hence, while symptoms can be devastatingly burdensome for mental health conditions such as schizophrenia, overwhelming evidence indicates that additional distress is caused persons with mental illness by negative attitudes from the general public. Thus, the damaging impact of stigma has been arguably compared to, and even considered worse than that of the symptoms (Coker, 2005; Feldman & Crandall, 2007; Hinshaw & Stier, 2008) thereby constituting a double jeopardy for sufferers. Yet, the burden

is worsened in sub-Saharan Africa where sufferers are additionally affected by destitution and face substandard care.

2.1.4.4 Impeding Help-seeking

The prejudice and discrimination that characterise the stigma of mental illness significantly contributes to the disconnect between effective treatments and care seeking (Corrigan et al. 2014). Research has underscored how stigma serves as a barrier to help-seeking for children (Adler & Wahl, 1998), adolescents (Chandra & Minkovitz, 2007), adults (Vogel, Wade, & Hackler, 2007), and elders (Graham et al., 2003). Stigma impacts care seeking at personal, provider, and system levels. Stigma and discrimination can impede access to care at institutional, community and individual levels as follows: institutional - legislation, funding, and availability of services (Corrigan, Watson, Warpinski & Gracia, 2004; Corrigan, Markowitz & Watson, 2004); community - public attitudes and behaviours (Evans-Lacko, Baum, Danis, Biddle & Goold, 2012); and individual - feeling ashamed to seek help, self-stigmatisation (Rüsch et al., 2009).

Stigma underlies the shame and secrecy associated with suffering from mental illness and the reluctance to self-disclose which inhibits access to care as sufferers are wary of how others will view them once they disclose their disorder (Byrne, 2000; Tanaka et al., 2003; Dinos et al., 2004). Similarly, they attempt to avoid the unfair discrimination and loss of opportunity that comes with stigmatizing labels by avoiding going to clinics or interacting with mental health providers with whom the prejudice is associated (Corrigan, 2004). Patients who are seen by non-psychiatric health workers in general health facilities are apprehensive of referral to psychiatrists or other mental health professionals (Regier et al, 1993; Hartley, Korsea, Bird & Agger, 1998). This arises in most circumstances for reasons that include; patients feeling more comfortable with non-psychiatric workers in general health facilities; and the desire to avoid being labelled mentally ill.

In a study of a rural Australian community (Fuller, Edwards, Procter, & Moss, 2000), the authors report that every person they interviewed concluded that mental health problems were associated with a high degree of stigma, and many suggested that they were associated with fear. A social worker in the study reports that ‘...a lot of people won’t come in (for treatment) because...mental health (has) got that stigma...you know, I’m not a nut case...’ and according to a telephone counsellor in the study: ‘...some are shocked when you ... try to give them a referral to a mental health service. Because they may think that’s only for weirdos, people who are mad’. A mental health consumer and advocate in the study similarly declared that: ‘...because of the stigma attached with mental illness...the last thing you want to do is to go into the system and seek help’. The conventional understanding of mental health problems as implying irremediable insanity leads to a fear about what happens to people who become clients within the mental health care system. The telephone counsellor further stated: ‘... [people] see mental health as like the one step on from...[the asylum]...like all the people in the white coats. “I don’t need that sort of thing”’. The implication is that even when people do recognise their distress, they may avoid formal mental health services, not perceiving them as an appropriate source of help. Owing to stigma, some would still not seek help even when the situation has become critical. The South African Federation of Mental health (2011) revealed that South Africans would rather die than admit to mental illness. Stigma is a powerful inhibitive factor for help-seeking even for battle-hardened soldiers; over 3000 military staff from US Army or Marine Corps units that had served combat duty in Iraq or Afghanistan were anonymously surveyed three to four months after their return. They were assessed for depression, anxiety, or post-traumatic stress disorder (PTSD). Most of the unhealthy soldiers (60-77%) did not seek mental health care mostly due to concerns about possible stigmatisation (Hoge et al., 2004).

It has also been argued that self-stigma is a much more potent stigma that may directly inhibit help seeking since the individual perceives the act of seeking professional help for distress as

a threat to their self-worth and as a weakness of character (Vogel & Wade, 2009; Vogel, Wade, & Haake, 2006). Families and relatives that are also stigmatised by association could hide ill relatives and not talk about their condition thus practically foreclosing access to care. Associative stigma could add to the burden of care which could lead to extreme measures such as child abuse, neglect or abandonment with a report alleging that some mothers of children with intellectual disabilities had considered doing away with their children in Nigeria (Abasiubong, Obembe & Ekpo, 2006). Thus, stigma leads to non-utilisation, underutilization or delay in the utilisation of mental health services, living in denial of mental health problems and early termination of mental health treatment. Delay in seeking medical treatment at the onset of illness results in symptoms being aggravated as patients try to cope on their own and the family is so frightened of the consequences of releasing this information (Tanaka et al., 2003).

Studying Arab clients in mental health settings, Al-Krenawi and Graham (2000) noted that stigma may have a particular gendered implication with the potential damage that mental health help-seeking could cause to present and future marital prospects of females including the possibility of divorce or the husband taking on a second polygamous wife. On the other hand, men may associate formal help-seeking with a diminishment of their masculinity and abilities to be strong providers and family leaders. Over 70% of Arab American women victims of domestic violence reported feelings of shame associated with seeking formal social services, and almost this number too reported embarrassment associated with reporting their problem to people outside of their family (Al-Krenawi et al., 2009).

2.1.4.5 Impeding Recovery

Stigma is arguably the most important obstacle to the appropriate treatment, rehabilitation, recovery, and the development of effective care and treatment for those suffering from mental illness (Sartorius, 2002; Pitre et al., 2007; Bell et al., 2008). It causes delays in diagnosis (Corrigan et al., 2001) and has also been identified as a primary obstacle to progress in mental

health prevention and research (Schomerus & Angermeyer, 2008; Greene-Shortridge et al. 2007; Thornicroft, 2008). People with mental illness receive less medical attention than others (Druss et al., 2001). The fear of madness begets social distancing which undermines the therapeutic efforts of service users and professionals reducing their ability to provide effective care (Foskett, Marriott & Wilson-Rudd, 2004). Using data from the 1990 National Comorbidity Survey in the US, Wang and colleagues (2002) estimated that only 20% of individuals with serious mental illnesses treated in general medical settings and 45.7% of those treated in specialty mental health settings received adequate treatment for their conditions.

Stigma and its attendant discrimination stall recovery and reintegration following a period of illness, and result in lost opportunities for fuller participation in life (Corrigan et al., 2001). Corrigan and colleagues (2004) noted that a major obstacle to the success of programmes, such as Supported Education Programme (SEP) for adults with schizophrenia which helps in the rehabilitation of persons with mental illness, is negative stigmatizing attitudes of the professionals responsible for the daily running of the programmes towards psychiatric disorders and persons with mental illness. In a national survey of users with mental health problems in New Zealand, service users reported discrimination in mental health services which included: failure to provide appropriate services and information, providing disrespectful or inappropriate treatment, failing to respect information from family members, or perpetuating negative stereotypes. They equally reported physical abuse, being talked about rather than to, feeling degraded, or being put down and ridiculed. Some felt abuse was often very subtle and specific to an individual staff member while others reported it as overt and endemic (The Mental Health Foundation of New Zealand, 2003).

Patients with mental illness who perceive devaluation or rejection by others have been shown to have worse outcome (Link et al., 1997). For instance, fear of stigma and lack of understanding of puerperal psychosis by families and healthcare professionals were linked to

the finding that women with a severe psychiatric disorder had a 70-fold increased risk of committing postnatal suicide and that mothers with mental illness who kill their children equally do so often as an extension of suicide (Appleby, Mortensen & Faragher, 1998; Craig, 2004; Spinelli, 2004). Consistent with the diathesis-stress model of schizophrenia (Comer, 2015), accentuation of environmental stressors such as job loss, rejection by suitors etc. associated with being stigmatized might equally contribute to relapse. Persistent structural stigma such as insurance barriers and inadequate systems of support lead to degeneration of poorly treated disease, additional disability, injury, or even death (Link & Phelan 2006; Stuart 2005). Limited funding and provider shortages hamper access to care especially for people with more disabling diagnoses such as schizophrenia and bipolar disorder in community mental health settings, particularly in poor and rural areas (Hough, Willging, Altschul, & Adelsheim, 2011).

Stigma can worsen symptoms and increase risk for co-morbid physical disease (Chapman, Perry & Strine, 2005). The rejecting attitudes of the health workers, on the other hand, lead to their inability to detect co-morbid physical illnesses in psychiatric patients and where they are detected, the patients are reluctantly and inappropriately cared for (Aghukwa, 2009a). Stigma could lead to medication non-compliance (Barney, Griffiths, Jorm & Christensen, 2006; Haghighat, 2001). Mkize and Uys (2004) reported how a client defaulted in treatment because of his siblings' negative reference to his treatment "Take your tablets for madness." A study of pathways to psychiatric care in Eastern Europe found a preference for 'mild' medicines (such as sedatives or hypnotics) which are less taboo to 'strong' medicines (such as antidepressants or antipsychotics) with connotations of severe mental illness (Gater et al., 2005).

2.1.5 Pervasiveness of Stigma

The form and nature may differ across cultures but stigmatisation of mental illness is present in all societies and in all classes of people (Levav et al., 2004; Björkman, Angelman & Jö

2008; Munro & Baker, 2007). Surveys of North America and Western Europe indicate that stigma is a major concern in the community. A comparison of datasets from 1950 national survey with a 1996 survey did not demonstrate a significant change in the stigmatising attitude of the American public who believe that people who experience psychosis are dangerous (Phelan et al., 2000). Using similar questions and similar study designs, 77% of respondents in Germany (Gaebel et al., 2002) and 75% in Canada (Stuart & Arbodella-Florez, 2001a) would be unwilling to have someone suffering from drug or alcohol dependency, schizophrenia, or depression marry a family member. The stereotype of dangerousness of people with mental illness is equally profound in Germany. Here, labelling also evoked the perception of neediness (Angermeyer et al., 2004). A mental health 'survivor' in a Canadian survey reported "I have to lie to my landlord to get a place to live, like tell him you are on disability, if it is not visible or physical, they don't take you. Even slumlords won't take you because they don't want psychiatrically ill people living in their buildings." 'Survivors' in the study reported that they felt ignored, avoided, or treated without respect and sensitivity (People Advocating for Change through Empowerment [P.A.C.E.] Report, 1996).

Sixty-seven per cent of respondents in Australia indicated that people with chronic schizophrenia are unpredictable (Griffiths et al., 2006) while a third of consumers with mental health problems in a New Zealand survey reported having been discriminated against by mental health services (The Mental Health Foundation of New Zealand, 2003). In Italy, where psychiatry has a long history of community treatments, a study conducted 10 years after the promulgation of the 1978 psychiatric reform law found that the general public held negative attitudes toward those with mental illness (Kemali et al., 1989). A study of Greek public attitude towards persons with mental illness found direct association of schizophrenia with criminality (Economou et al., 2005) while a large-scale representative national survey of

the British adult population found pervasive negative opinions that exaggerated the handicaps of mental illness (Crisp et al., 2000).

In September 2013, the supermarket chains Tesco and Asda were forced to apologise following public outcry in the UK against their stereotypical association of mental illness with the weird ghost of Halloween. Asda had produced 'mental patient fancy dress costume' with the catchphrase "Everyone will be running away from you in fear in this mental patient fancy dress." Tesco equally had a costume called 'Psycho Ward' on its shelves. Earlier in March 2006, the BBC and other media reported the public outcry against the statue of the Prime Minister Winston Churchill in a straitjacket which was commissioned by the mental health charity 'Rethink' and unveiled in the Norwich area to draw attention to and stamp out the stigma surrounding mental health. Churchill was chosen because despite dealing with the symptoms of manic depression throughout his life, he was able to become Prime Minister, lead the country during the World War II and was voted "The Greatest Briton" in a national poll. But the public, including the politician's family and World War II veterans interpreted the concept as 'distasteful', 'absurd' and 'pathetic' and their complaints eventually led to the removal of the sculpture.

Similarly, a coffee shop run by people with mental health problems in China was forced to shut down due to protests of the local community (Song et al., 2005). Another Chinese study noted that persons with mental illness are always seen as potential sources of social instability because it is feared that they are volatile (Park, Xiao, Worth & Park, 2005). Associative stigma is equally rife in the Chinese collectivist culture where mental illness is highly stigmatizing for the whole family not just the individual afflicted. The emphasis on collective responsibility leads to the belief that mental illness is a family problem. Care-giving is thus retained within the context of the family for as long as possible which results in delay in getting professional help (Ryder, Bean & Dion, 2000). About 80% of Japanese respondents agreed with a landlord's decision not to rent a house to someone with mental illness (Tanaka

et al., 2006). Marriage prospects, fear of rejection by neighbours, and the need to hide the illness from others were among the additional concerns of people with schizophrenia and their caregivers in India (Thara & Srinivasan, 2000). In the Erwadi tragedy in South India in 2001, more than 20 persons with mental illness were burnt to death when a fire swept one of the treatment shelters near the healing mosque where they were chained to their beds (Murthy, 2001).

Earlier studies had claimed that stigmatizing attitude towards persons with mental illness is less evident in traditional non-Western societies such as Africa (Carothers, 1948; Fabrega, 1991; Cheetham & Rzakdowski, 1980). Cooper and Sartorius (1977) noted the suggestion that social representation of mental diseases in pre-industrialized and threshold countries with less differentiation between mental and physical illnesses as well as a religious dimension in the conceptualization of mental illness have a preventive effect on stigmatization. Disputing this claim however, a renowned African psychiatrist and mental health scholar Oye Gureje reports that it borders on the exotic and reflects an erroneous tendency to present Africa as some sort of El dorado where, unlike in “civilized communities”, no distinction is made between the sane and the insane, with everybody living together in blissful happiness (Gureje, 2007). He went further to articulate the common knowledge that in Africa, patients with mental illness are socially alienated and abused as a result of their illness, often along with their families. Disaffiliated families often abandon and disown their sick members because of societal stigma and shame.

A study of Moroccan families of patients with schizophrenia found that most of the families suffer from stigma and discrimination with a total of 86.7% reporting that they have hard lives because of the illness, and 72% reporting psychological suffering caused by sleep and relationship disturbances and a poor quality of life (Kadri, Manoudi, Berrada & Moussaoui, 2004). An Ethiopian survey revealed a widespread experience of stigma by people with mental illness with three quarters of their family members also experiencing stigma (Shibre et

al., 2001). Only a quarter of a Malawian study sample believed that mental illness could be treated outside of the hospital setting (Crabb et al., 2012).

Negative attitude towards people with mental illness is prevalent in Nigerian communities. In a seminal work (Gureje et al., 2005) which investigated community knowledge of and attitude toward mental illness in south-western Nigeria, most of the respondents thought that people with mental illness were mentally retarded, public nuisances, dangerous because of their violent behaviour and could not be treated outside the hospital. Only about a quarter thought that persons with mental illness could work in regular jobs. The five most endorsed personal attributes of persons with mental illness in a survey of doctors in the same south-western Nigeria included: unpredictability, dangerous, lacking self-control, aggressive and dependence. There was equally pessimism of prognosis with only 9% of doctors believing that mental illness could be cured (Adewuya & Oguntade, 2007). More than a third of healthcare providers surveyed in south-southern Nigeria indicated that they would indeed shun or out-rightly reject family members suffering from mental illness (Ewhrudjakpor, 2009). The study equally reported a primitive system of management as in 2006, the state Ministry under which the care of persons with mental illness fell, had successfully gathered vagrants suffering with psychosis and quarantined them with the help of native doctors who were charged with 'managing' their decline.

Similarly, in a more recent exercise, against their constitutional right of abode in any part of the country, the Lagos state government in south-western Nigeria gathered some destitute vagrants suffering with psychosis, herded them in a truck, and 'deported' them to their states of origin in the eastern part of the country where they were abandoned and some reportedly died after some days (Okpi, 2013; Adeniyi, 2013). Such situations are not helped by the lack of expeditious enactment of enabling laws in Nigeria. For instance, the mental health bill proposed by the Association of Nigerian Psychiatrists is yet to be passed into law. The existing

legislation dates back to British colonial laws of 1916 that were later revised as the Lunacy Act in 1958, with the quite stigmatising caption.

2.1.6 Rationale for study and aims

Deinstitutionalisation is a major paradigm shift in the care of people with mental illness in the second half of the 20th century. The role of the community in the prevention and care of the mentally handicapped has now been widely acknowledged as the most appropriate basis for the development of community mental health programmes (Dessoki & Hifnawy, 2009). Knowledge of public attitudes to mental illness and its treatment is crucial to the realization of successful community-based programmes. The World Psychiatric Association (2002) furthermore acknowledged that the assessment of the community attitude to mental illness and surveys of target groups with defined attributes are required to implement effective educational and anti-stigma programmes. Moreover, culture influences the experience, expression, and determinants of stigma, and the effectiveness of different approaches to stigma reduction (Al-Krenawi et al., 2009; Shulman & Adams, 2002; Angermeyer & Matschinger, 2003). Any meaningful intervention to combat stigma therefore need take into consideration the cultural context. However, an unmet need for further research into this phenomenon in non-Western cultures has been noted (Bhugra, 2006; Yang, 2007). This study explores the attitudes of a cross-section of Igbo people of south-eastern Nigeria in response to this gap in sub-Saharan Africa.

The aims of this segment of the research include:

1. To explore the extent to which the Igbo people in Nigeria vs. those in the UK demonstrate negative attitude towards people with mental illness.
2. To explore the extent they desire social distance from sufferers of mental illness.
3. To determine the demographic predictors of negative attitudes and desire for social distance.

4. To measure negative attitudes and desire for social distance compared across demographic groups
5. To consider the determinants of negative attitudes and desire for social distance.
6. To consider the possible implications of negative attitudes and desire for social distance both in Nigeria and in the UK.
7. To develop materials for a new measure of social distance.

There are four parts to the study: Study 2a explores attitudes towards people with mental illness; Study 2b develops a quantitative Social Distance instrument; Study 2c used the Social Distance scale for an initial exploratory study; Study 2d used the validated Social Distance scale for the substantive confirmatory study.

2.2 Methods

2.2.1 Participants and Sampling Technique

Multi-stage (random and opportunity) sampling was used to select participants for the exploratory studies 2a (on attitudes towards people with mental illness) and 2c (on social distance desired from people with mental illness) which were conducted simultaneously $n = 602$. The first stage of sampling involved a random selection of three out of the five Igbo states through a balloting process; Anambra, Enugu, and Imo states were selected. The second stage of sampling involved the selection of a semi-urban locality from each of the three states based on their relative accessibility and proximity. This equally served to survey a more representative demographic with both urban and rural characteristics. One co-educational school and a university were selected from each state for the survey of students and a community hospital with a school of nursing was similarly selected for the survey of nurses. However, convenience sampling method was used to select participants from across the five Igbo states for the confirmatory study 2d (on desired social distance) which was conducted together (same sample) with the rest of the confirmatory studies across the research as noted in

Chapter one $n = 1127$ (Nigeria-based) and $n = 105$ (UK-based general public sample). The same demographics were explored in the three (2a, 2c and 2d) studies and they are as described in study 1b.

2.2.2 Instruments

The Community Attitudes to Mental Illness scale (CAMI) by Taylor and Dear (1981) was adapted for Study 2a (attitudes towards people with mental illness). It is a 40-item self-report inventory developed to gauge community rather than professionals' attitudes toward people with mental illness. It consists of four subscales measuring two negative and two positive constructs: Authoritarianism (which sees a clear difference between persons with mental illness and others and proposes hospitalisation for them); Social Restrictiveness (which expresses beliefs that people with mental illness are dangerous and are to be avoided or restricted); Benevolence (which expresses sympathy toward persons with mental illness and acknowledges public responsibility to help them) and Community Mental Health Ideology (which reflects acceptance of mental health services and people with mental illness in the community). Each of the items had a four-point Likert response scale: strongly agree, agree, disagree and strongly disagree. Participants' responses were reclassified as agreeing to a proposition if the response were either 'strongly agree' or 'agree' to the items and disagreeing with the proposition if the responses were 'strongly disagree' or 'disagree'. Twenty-one of the statements were negatively worded; scores for the items were therefore reversed during data entry. The internal consistency reliability coefficients for the four sub-scales were as follows: Authoritarianism .63; Benevolence .76; Social Restrictiveness .80 and Community Mental Health Ideology .88. As deinstitutionalisation represents a major paradigm shift in the care and management of people with mental illnesses, the major strength of the scale is its exploration of community rather than professional attitudes toward community-based care. However, the scale was developed in an Anglo-Saxon cultural context with some concern that it is possibly anglicised (Högberg et

al., 2008). This informed the consideration to balance it with a social distance scale (Study 2b) emergent from the cultural context of the study. The latter scale was developed from items pulled from the content analysis of qualitative data gathered from the target (Igbo) population. The qualitative data was collected in text form; respondents were asked to list the relationships they could hold with people without mental illness which they could not possibly hold with people with mental illness. Some of the responses that were elicited include: 1. 'I could not do business with someone that is mentally ill'; 2. 'I would never marry nor even live in the same neighbourhood with someone that is mentally ill'. Content analysis was used to create codeable units from the data. Units were defined based on one relationship communicated. For instance, two units (marriage and sharing of neighbourhood) were defined from the second response reported above. Units were defined (picked) only once irrespective of their frequency of occurrence in the data. Twenty units were realised in all making up the 20 potential items for quantitative instrument. Questions were framed to elicit response to the idea expressed in each of the units e.g. could you marry someone cured of mental illness? The questions were framed with a four-point Likert response scale: strongly agree, agree, disagree and strongly disagree. These were subsequently deployed in gathering the quantitative data. To further refine the scale, following the entry of the quantitative data into SPSS, the 20 items were subjected to the Principal Component Analysis (PCA) (Stevens, 1996). Prior to performing PCA, the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of many coefficients at .3 and above. The Kaiser-Meyer-Olkin value was .96, exceeding the recommended value of .6 (Kaiser, 1970, 1974) and Bartlett's Test of Sphericity (Bartlett, 1954) was highly significant, ($p < .001$) supporting the factorability of the correlation matrix. The PCA result is provided in the result section.

2.2.3 Data Collection

The details of data collection are as in Chapter One (Section 1.2.3). A high response rate of 97.3% was achieved for studies 2a (on attitudes towards people with mental illness) and 2c (exploratory study on desire for social distance) which were conducted on the same sample.

The response rate for Study 2d (confirmatory study on desire for social distance) was the same as has been reported in the confirmatory study of Chapter One (Section 1.2.3) given that all confirmatory studies were with the same sample.

2.2.4 Data analysis

Data was analysed as has been described in Chapter One section 1.2.4. However, in place of logistic regressions, two-sample chi-square tests were performed to determine the association between the demographic characteristics and the attitude, and social distance constructs. Phi and Cramer's V were used as measures of effect size.

2.3 Results

2.3.1 Study 2a (Attitudes towards persons with mental illness using the CAMI scale)

The demographic characteristics of the sample are summarised in Table 2.1.

Table 2.1 Socio-demographic Characteristics of Studies 2a (on Attitudes) and 2c (exploratory on Soc. Distance)

Characteristics	N	%
Gender		
Male	240	39.9
Female	362	60.1
Age		
Young	460	76.4
Old	142	23.6
Marital Status		
Not married	397	65.9
Married	205	34.1
Educational Status		
Low education	207	34.1
High education	395	65.9
Religious Denomination		
Protestant	210	34.9
Catholic	392	65.1
Familiarity with Mental Illness		
Not familiar	185	30.7
Familiar	417	69.3
Occupation		
General public	166	27.6
Students	200	33.2
Teachers	122	20.3
Nurses	114	18.9

There were more female (60.1%), young (76.4%) and unmarried (65.9%) respondents. There were also more respondents with higher education (65.9%) and more Catholics (65.1%). The majority of the respondents (69.3%) were familiar with persons with mental illness.

Table 2.2 Association of Demographic Characteristics with Attitudinal Constructs of the Community Attitudes to Mental Illness (CAMI) scale (Study 2a)

Characteristics		Attitude Constructs																							
		Authoritarianism						Benevolence						Social Restrictiveness						Community Care					
		Disagree		Agree		X ²	P-value	Disagree		Agree		X ²	P-value	Disagree		Agree		X ²	P-value	Disagree		Agree		X ²	P-value
n	%	n	%	n	%			n	%	n	%			n	%	n	%			n	%	n	%		
Gender	Female	75	21.7	271	78.3	3.18	.08	10	2.9	335	97.1	.17	.68	244	70.3	103	29.7	7.92	.01**	86	24.8	261	75.2	9.91	.01**
	Male	36	15.4	198	84.6			9	3.9	223	96.1			136	58.6	96	41.4			86	37.4	144	62.6		
Age	Young	76	17.2	336	82.8	4.02	.05*	10	2.2	436	97.8	5.44	.05*	306	68.9	138	31.1	8.52	.01**	107	24.2	335	75.8	27.20	.00***
	Old	35	25.4	103	74.6			9	6.9	122	93.1			74	54.8	61	45.2			65	48.1	70	51.9		
Marital Status	Not Married	67	17.6	313	82.4	1.35	.25	11	2.9	374	97.1	.340	.56	260	68.2	121	31.8	3.04	.08	86	22.6	295	77.4	27.09	.00***
	Married	44	22.0	156	78.0			8	4.2	184	95.8			120	60.6	78	39.4			86	43.9	110	56.1		
Educ. Status	Low Educ.	23	11.8	172	88.2	9.53	.01**	11	5.4	191	94.6	3.54	.06	115	57.5	85	42.5	8.41	.01**	70	35.2	129	64.8	3.80	.05*
	High Educ.	88	22.9	297	77.1			8	2.1	367	97.9			265	69.9	114	30.1			102	27	276	73		
Religious Denomi- nation	Protestant	33	16.8	164	83.2	.877	.35	10	5.0	192	95.0	1.94	.16	131	64.5	72	35.5	.10	.75	66	32.4	138	67.6	.80	.37
	Catholic	78	20.4	305	79.6			9	2.4	366	97.6			249	66.2	127	33.8			106	28.4	267	71.6		
Familiarity	Not Familiar	17	9.7	159	90.3	13.80	.00***	5	2.9	166	97.1	.00	.95	110	62.5	66	37.5	.91	.34	52	29.1	127	70.9	.03	.87
	Familiar	94	23.3	310	76.7			14	3.4	392	96.6			270	67.0	133	33.0			120	30.2	278	69.8		
Occupation	Gen. Public	20	12.4	141	87.6	49.58	.00***	6	12.4	147	87.4	5.30	.15	103	64.8	56	35.2	21.37	.00** *	57	36.1	101	63.9	38.42	.00***
	Students	20	10.6	169	89.4			7	3.6	188	96.4			115	59.9	77	40.1			54	27.8	140	72.2		
	Teachers	25	21.0	94	79.0			6	5.1	111	94.9			69	59.0	48	41.0			51	44.7	63	55.3		
	Nurses	46	41.4	65	58.6			0	0.0	112	100			93	83.6	18	16.2			10	9.0	101	91.0		
Cumulative Score		111	19.1	469	80.9			19	3.3	558	96.7			380	65.6	199	34.4			172	29.8	405	70.2		

Significance level: * = p<0.05, ** = p<0.01, *** =p<0.001

The cumulative pattern of attitude endorsements as presented in Table 2.2 showed that as much as four in five (80.9%) of the respondents endorsed authoritarian attitude towards people with mental illness. Close to two-thirds (64.4%) of the sample would not want to associate with people with mental illness at more personal (primary) level. Above a third (35.9%) would prefer to have no dealings with persons with mental illness even at the more distal (secondary) level of association. Similarly, a third (34.4%) of the respondents felt that people with mental illness should be socially restricted while over a quarter (29.8%) would be opposed to caring for them in the community. However, only a negligible 3.3% demonstrated non-benevolent attitude.

Table 2.2 equally shows the association of demographic characteristics of the respondents with attitudinal constructs of mental illness. The results revealed significant association between Education and most of the attitude constructs including: Authoritarianism ($X^2 (1, n = 580) = 9.53, p < .05, \phi = -.13$) with participants who had low education (88.2%) demonstrating more authoritarian attitudes than those with high education (77.1%); Social Restrictiveness ($X^2 (1, n = 579) = 8.41, p < .05, \phi = -.12$) with participants who had low education (42.5%) endorsing more social restrictive attitudes than those with high education (30.1%) and Community Health Ideology ($X^2 (1, n = 577) = 4.18, p < .05, \phi = .09$) with participants who had high education (73%) demonstrating more pro-community care attitudes than those with low education (64.8%). Familiarity with mental illness was significantly associated with Authoritarianism ($X^2 (1, n = 580) = 13.80, p < .001, \phi = -.16$) with those not familiar with someone with mental illness (90.3%) demonstrating more authoritarian attitudes than those familiar with someone with mental illness (76.7%).

Age was associated with Community Health Ideology ($X^2 (1, n = 577) = 27.19, p < .001, \phi = -.22$) with the young (75.8%) demonstrating more pro-community care attitudes than the old (51.9%) and Benevolence ($X^2 (1, n = 577) = 5.44, p < .05, \phi = -.10$) with the young (97.8%) demonstrating more benevolent attitudes than the old (93.1%). Age was equally associated with Social Restrictiveness ($X^2 (1, n = 579) = 8.51, p < .05, \phi = .13$) with the old (45.2%) endorsing

more social restrictive attitudes than the young (31.1%) and Authoritarianism ($X^2 (1, n = 580) = 4.02, p < .05, \phi = -.08$) with the young (82.8%) demonstrating more authoritarian attitudes than the old (74.6%). Marital Status was associated with Community Health Ideology ($X^2 (1, n = 577) = 27.09, p < .001, \phi = -.22$) with the unmarried (77.4%) demonstrating more pro-community care attitudes than the married (56.1%). Gender was associated with Social Restrictiveness ($X^2 (1, n = 579) = 7.92, p < .05, \phi = .12$) with males (41.4%) endorsing more social restrictive attitudes than females (29.7%) and Community Health Ideology ($X^2 (1, n = 577) = 9.91, p < .05, \phi = -.14$) with females (75.2%) demonstrating more pro-community care attitudes than the males (62.6%). There was a significant relationship between Occupation and Authoritarianism ($X^2 (3, n = 580) = 49.58, p < .001, \phi_c = .29$). While Nurses demonstrated a relatively moderate degree of authoritarianism (58.6%), the General Public (87.6%), Students (89.4%) and Teachers (79%) all demonstrated a common pattern of high degree of authoritarianism. There was also a significant relationship between Occupation and Social Restrictiveness ($X^2 (3, n = 579) = 21.37, p < .001, \phi_c = .19$). Nurses also endorsed a relatively lower degree of Social Restrictiveness (16.2%) while the General Public (35.2%), Students (40.1%) and Teachers (41%) all endorsed higher degrees of Social Restrictiveness. Occupation was also associated with Community Health Ideology ($X^2 (3, n = 577) = 38.42, p < .001, \phi_c = .26$); Teachers demonstrated the least pro-community care attitudes with the moderate score of 55.3% while Nurses demonstrated the most pro-community care attitudes with the high score of 91% with the General Public (63.9%) and the Students (72.2%) coming in-between.

2.3.2 Principal Component Analysis (Study 2b)

PCA revealed the presence of 3 components with eigenvalues exceeding 1, explaining 47.40%, 6.75% and 5.14% of the variance. Following Oblimin rotation, two components showed a number of strong loadings. Retention of two components was further supported by the inspection of the scree plot which revealed a prominent levelling off of the slope after the second component. Items that proposed primary (more intimate) association with persons with mental

illness such as ‘Would you marry someone cured of mental illness?’ loaded strongly on the first component while items that proposed secondary (less intimate) association such as ‘Would you share your neighbourhood with someone cured of mental illness?’ loaded strongly on the second. Factor loadings are shown in Table 2.3.

Table 2.3 Factor loadings for Social Distance Scale (SDS)

Items	Factors		
	1	2	3
Item 1. Would you let one who recovered from mental illness care for your children?	.905		
Item 2. Would you employ someone who has recovered from mental illness as house-help?	.779		
Item 3. Would you marry someone cured of mental illness?	.764		
Item 4. Would you have someone cured of mental illness as your surety or witness?	.727		
Item 5. Would you be driven in a car by one who has recovered from mental illness?	.683		
Item 6. Would you have a nurse cured of mental illness inject you?	.669		
Item 7. Would you employ one who has recovered from mental illness as security?	.632		
Item 8. Would you confide in someone cured of mental illness?	.560		
Item 9. Would you do business with one who has recovered from mental illness?	.416	.396	
Item 10. Would you play or share jokes with someone who has been cured of mental illness?		.887	
Item 11. Would you share neighbourhood with someone cured of mental illness?		.856	
Item 12. Would you rent a house to someone cured of mental illness?		.749	
Item 13. Would you seek advice of someone cured of mental illness?		.706	
Item 14. Would you share belongings with someone cured of mental illness?		.661	
Item 15. Would you be friends with one who has been cured of mental illness		.586	
Item 16. Would you have someone who has been cured of mental illness barb/make your hair?		.565	
Item 17. Would you sleep in the same room with one cured of mental illness?	.332	.518	
Item 18. Would you serve as surety or witness for someone cured of mental illness?		.501	
Item 19. Would you feel ashamed if someone in your family becomes mentally ill?			.678
Item 20. Would you argue with someone who has been cured of mental illness?	.416		-.520

Cronbach’s alpha and item-total correlations were computed for each of the two factors and each of the scale constructs demonstrated internal consistency with Cronbach alpha coefficient of 0.90. The items had a four-point Likert response scale of: yes, possibly, unlikely and no. Responses of ‘yes’ and ‘possibly’ were categorized as assenting to a proposition while responses of ‘unlikely’ and ‘no’ were categorized as dissenting to a proposition.

2.3.3 Study 2c (Exploratory study of Social Distance desired from people with mental illness)

The demographic characteristics of the sample are summarised in Table 2.1 (see 2.3.1 above).

Table 2.4 Association of Demographic Characteristics with Social Distance Constructs (Exploratory Study 2c)

Characteristics		Attitude Constructs											
		Primary Social Distance						Secondary Social Distance					
		Disagree		Agree		X ²	P-value	Disagree		Agree		X ²	P-value
n	%	n	%	n	%			n	%				
Gender	Female	116	32.9	237	67.1	2.53	.11	224	64.0	126	36.0	.000	1.00
	Male	92	39.7	140	60.3			146	64.2	83	35.8		
Age	Young	159	35.3	291	64.7	.011	.92	294	66.1	151	33.9	2.90	.09
	Old	49	36.3	86	63.7			79	57.7	58	42.3		
Marital Status	Not Married	134	34.6	253	65.4	.320	.57	251	65.7	131	34.3	1.07	.30
	Married	74	37.4	124	62.6			122	61.0	78	39.0		
Educational Status	Low Education	49	24.5	151	75.5	15.49	.00***	112	55.7	89	42.5	8.80	.01**
	High Education	159	41.3	226	58.7			261	68.5	120	30.5		
Religious Denomination	Protestant	62	30.1	144	69.9	3.78	.05*	115	57.5	85	42.5	5.32	.05*
	Catholic	146	38.5	233	61.5			258	67.5	124	32.5		
Familiarity with Mental Illness	Not Familiar	56	30.8	126	69.2	2.35	.13	101	56.7	77	43.3	5.56	.05*
	Familiar	152	37.7	251	62.3			272	67.3	132	32.7		
Occupation	Gen. Public	55	34.2	106	65.8	4.01	.26	103	63.6	59	36.4	3.41	.33
	Students	62	32.0	132	68.0			120	61.9	74	38.1		
	Teachers	51	42.9	68	57.1			72	61.5	45	38.5		
	Nurses	40	36.0	71	64.0			78	71.6	31	28.4		
Overall Score		208	35.6	377	64.4			373	64.1	209	35.9		

Significance level: * = $p < 0.05$, ** = $p < 0.01$, *** = $p < 0.001$

The cumulative pattern of attitude endorsements in the Exploratory study as presented in Table 2.4 showed that almost two-thirds (64.0%) of respondents would not want to associate with people with mental illness at the more personal (primary) level while a third (35.9%) would prefer not to have dealings with persons with mental illness even at the more distal (secondary) level of association. Table 2.4 also shows the association of demographic characteristics of the respondents with Social Distance constructs. The results revealed significant association between Education and Primary Social Distance ($X^2 (1, n = 585) = 15.49, p < .001, \phi = -.17$) with participants who had low education (75.5%) demonstrating desire for primary social distance more than those with high education (58.7%). There was also a significant association between Education and Secondary Social Distance ($X^2 (1, n = 582) = 8.80, p < .05, \phi = -.13$) with participants who had low education (42.5%) demonstrating desire for secondary social distance more than those with high education (30.5%). Familiarity was also associated with Secondary Social Distance ($X^2 (1, n = 582) = 5.56, p < .05, \phi = -.10$) with those not familiar with someone with mental illness (43.3%) demonstrating desire for secondary social distance more than those familiar with someone with mental illness (32.7%). Religious Denomination was associated with Primary Social Distance ($X^2 (1, n = 585) = 4.14, p < .05, \phi = -.08$) with the Protestants (69.9%) demonstrating desire for primary social distance more than the Catholics (61.5%) and Secondary Social Distance ($X^2 (1, n = 582) = 5.32, p < .05, \phi = .10$) with the Protestants (42.5%) also demonstrating desire for secondary social distance more than the Catholics (32.5%).

2.3.4 Study 2d (Confirmatory study of Social Distance desired from people with mental illness)

For the demographic characteristics of the confirmatory study sample (which is same across the studies) see as summarised in Table 1.9 (Chapter One, section 1.3.2).

Table 2.5 Association of Demographic Characteristics with Social Distance Constructs (Confirmatory Study)

Characteristics		Attitude Constructs											
		Primary Social Distance						Secondary Social Distance					
		Disagree		Agree		X ²	P-value	Disagree		Agree		X ²	P-value
n	%	n	%	n	%			n	%				
Gender	Female	102	14.0	624	86.0	.08	.77	349	47.2	391	52.8	.09	.76
	Male	48	15.0	273	85.0			164	48.4	175	51.6		
Age	Young	114	15.4	628	84.6	1.65	.20	395	51.3	375	48.7	13.62	.00***
	Old	36	12.0	263	88.0			116	38.5	185	61.5		
Marital Status	Not Married	107	16.7	534	83.3	7.04	.01**	359	53.9	307	46.1	28.06	.00***
	Married	42	10.6	356	89.4			150	37.0	255	63.0		
Educational Status	Low Education	22	11.3	173	88.7	1.67	.20	67	34.2	129	65.8	16.95	.00***
	High Education	129	15.2	719	84.8			446	50.7	433	49.3		
Religious Denomination	Protestant	61	14.4	362	85.6	.01	.94	206	47.5	228	52.5	.05	.83
	Catholic	87	14.8	501	85.2			294	48.4	314	51.6		
Familiarity with Mental Illness	Not Familiar	34	10.0	306	90.0	8.33	.01**	147	41.8	205	58.2	10.05	.01*
	Familiar	107	17.1	519	82.9			338	52.5	306	47.5		
Occupation	Gen. Public	28	11.0	227	89.0	14.14	.01**	104	39.4	160	60.6	54.64	.00***
	Students	25	11.8	186	88.2			89	40.8	129	59.2		
	Teachers	31	12.4	218	87.6			101	39.1	157	60.9		
	Nurses	63	20.7	241	79.3			201	64.6	110	35.4		
Overall score (Nigeria-based) Sample		151	14.3	902	85.7			516	47.6	569	52.4		
General Public	Nigeria	28	11.0	227	89.0	29.54	.00***	104	39.4	160	60.6	10.46	.01*
	UK	36	36.4	63	63.6			60	58.8	42	41.2		

Significance level: * = $p < 0.05$, ** = $p < 0.01$, *** = $p < 0.001$

The cumulative pattern of attitude endorsements in the Confirmatory study as presented in Table 2.5 showed that more than 4 in 5 (85.7%) of Nigeria-based respondents would not want to associate with people with mental illness at the more personal (primary) level while more than half (52.4%) would prefer not to have dealings with persons with mental illness even at the more distal (secondary) level of association. On the other hand, close to two-thirds (63.6%) of the UK-based respondents would not want to associate with people with mental illness at primary level while 2 in 5 (41.2%) would prefer not to have dealings with persons with mental illness at secondary level of association.

The association of demographic characteristics of respondents with social distance constructs revealed significant relationship between Age and Secondary Social Distance ($X^2 (1, n = 1071) = 13.62, p < .001, \phi = .12$) with older respondents (61.5%) demonstrating desire for secondary social distance more than the younger respondents (48.7%). There was significant association between Marital Status and both Primary ($X^2 (1, n = 1039) = 7.04, p < .01, \phi = .09$) and Secondary Social Distance ($X^2 (1, n = 1071) = 28.06, p < .001, \phi = .16$) with the married demonstrating desire for both Primary (89.4%) and Secondary Social Distance (63.0%) more than the unmarried 83.3% and 46.1% respectively. There was significant relationship between Education and Secondary Social Distance ($X^2 (1, n = 1075) = 16.95, p < .001, \phi = -.13$) with participants who had low education (65.8%) demonstrating desire for secondary social distance more than those with high education (49.3%). There was significant association between Familiarity and both Primary ($X^2 (1, n = 966) = 8.33, p < .01, \phi = -.10$) and Secondary Social Distance ($X^2 (1, n = 996) = 10.05, p < .01, \phi = -.10$) with those not familiar with person(s) with mental illness demonstrating desire for both Primary (90.0%) and Secondary Social Distance (58.2%) more than those who are familiar with person(s) with mental illness 82.9% and 47.5% respectively. There was a significant relationship between Occupation and Primary Social Distance ($X^2 (3, n = 1019) = 14.14, p < .01, \phi_c = .12$). While Nurses demonstrated relatively lower degree of Primary Social Distance from person(s) with mental illness (79.3%), the General

Public (89.0%), Students (88.2%) and Teachers (87.6%) all demonstrated a common pattern of higher desire of Primary Social Distance. There was also a significant relationship between Occupation and Secondary Social Distance ($X^2(3, n = 1051) = 54.64, p < .001, \phi_c = .23$). While Nurses demonstrated low degree of Secondary Social Distance from person(s) with mental illness (35.4%), the General Public (60.6%), Students (59.2%) and Teachers (60.9%) all demonstrated a common pattern of higher desire of Secondary Social Distance.

Table 2.5 also showed that 89% of the Nigeria-based and 63% of the UK-based general public would not want to associate with people with mental illness at more personal (primary) level. On the other hand, 60.6% of the Nigeria-based and 41.2% of the UK-based general public would prefer to have no dealings with persons with mental illness at the more distal (secondary) level of association. An independent sample t-test showed that the difference in the demonstration of desire for Primary Social Distance by the Nigeria-based ($M = 3.31, SD = .59$) and the UK-based ($M = 2.87, SD = .81$) general public samples was statistically significant, $t(353) = 4.94, p = .001$, (two-tailed). The magnitude of the differences in the means (mean difference = .44, 95% *CI*: .26 to .61) was moderate (eta squared = .09). The difference in the demonstration of desire for Secondary Social Distance by the Nigeria-based ($M = 2.74, SD = .81$) and the UK-based ($M = 2.87, SD = .81$) general public samples was also statistically significant, $t(364) = 4.98, p = .001$, (two-tailed). The magnitude of the differences in the means (mean difference = .46, 95% *CI*: .28 to .65) was also moderate (eta squared = .06).

2.4 Discussion

This chapter investigated the attitudes of the Igbo people towards persons with mental illness and the degree of social distance desired from persons with mental illness. Pervasive negative attitudes were evident with more than half of all the demographic groups (nurses, teachers, students and the general public) demonstrating authoritarian attitudes and desiring social distance at primary (more intimate) levels of relationships. Over a third of the nurses and more than half

of those in the non-nursing occupational groups also desired social distance at secondary levels of association. About a third of all the groups also endorsed socially restricting persons with mental illness and demonstrated opposition to their care in community (deinstitutionalisation). Thus, the findings add to the refutation of earlier submissions which had claimed that non-Western traditionalist societies appear immune to stigmatising attitudes towards people with mental illness. It gives support to the suggestion that the earlier reports may have been due to paucity of research rather than a more receptive attitude towards mental illness (Alem & Kebede, 2003; Corrigan & Watson, 2002).

Four in five respondents (80.9%) endorsed authoritarianism which sees a clear difference between persons with mental illness and others and proposes immediate hospitalisation for them. The fundamental characteristic of stigma is difference (Link & Phelan, 2001) which can easily be spotted in collectivist cultures like the Igbo culture that stress conformity. Difference could be particularly more pronounced with a person with mental illness who may ostensibly deviate from the norm or demonstrate lapses in social integration. Indeed, most Nigerian societies see mental illness as a deviation from normality (Ewurdjakpor, 2009). This possibly explains why almost all of the respondents in the study (94.7%) see people with mental illness as 'different' while a similarly significant proportion (91.5%) endorsed the immediate hospitalisation of anyone that shows signs of mental illness. Levey and Howells (1995) also found that people with psychotic conditions such as schizophrenia are thought of as being essentially 'different' in terms of their perceived unpredictability and dangerousness which underpins the widespread fear of schizophrenia held by many.

On a similar note, aesthetics, which in relation to stigma denotes the extent to which a mark elicits an instinctive and affective reaction of disgust (Jones et al., 1984) constitutes a key distinguishing feature of persons with mental illness from the rest of the community in this region where the common spectacle of persons with mental illness is that of unkempt vagrants with psychosis (Ewurdjakpor, 2010; Atilola & Olayiwola, 2011). This is reinforced by the

consideration that the social representation about the body is centred on beauty and well being (Goetz, Camargo, Bertoldo & Justo, 2008). Associating people with mental illness with filth in this context has become so normative that it has earned a place in the people's repertoire of proverbs. For instance, to highlight the professional 'dirty' appearance of motor garage mechanics, there is a saying that 'with the way they appear (dirty in their working garbs), one is no longer able to distinguish who the real mad man is.' It was such concern with aesthetics that led a state government in Nigeria to quarantine vagrants with psychosis with a view to ultimately phasing them out of existence while another state government 'deported' them to their states of origin in the bid to tidy up the streets of the state (cf. section 2.1.5).

It has been observed that as a rule and for all disorders, the level of social distance desired from people with mental illness increases with the degree of "intimacy" implied by the relationship (Gaebel et al., 2002; Stuart & Arboleda-Floréz, 2001b). This is corroborated in this study with social distance desired at the primary (more intimate) level of association being more significantly endorsed (64.4%) compared to that desired at the secondary (less intimate) level of association (35.9%). Indeed, primary social distance was the most expressed negative attitude construct by both the Nigeria (89.0%) and UK based (63.3%) general public sample. Social distance is mostly influenced by stereotypes of dangerousness and unpredictability (Grausgruber et al., 2007; Angermeyer et al., 2004). In the eyes of the general public, 'madness' equates to 'violence' (Ewurdjakpor, 2009) and many hold stereotypical views of persons with mental illness in which psychotic behaviour is expected (Pilgrim, 2005). A real or imagined fear of aggression could therefore lead to avoidance of people with mental illness. For instance, following the Hungerford massacre of 1987, Appleby and Wessely (1988) reported a statistically significant increase in public support for the statement that 'people who commit horrific crimes, such as murder of children or old people, are likely to be mentally ill.' Mental illness is thus associated with disruptive and unpredictable behaviours which will meet with public disapproval expressible in social distance and endorsement of social restrictiveness as done by a third of

respondents in this study. This would be particularly reinforced in the Nigerian context where the gravity of psychiatric illness is mostly judged on behavioural grounds with aggression/destructiveness topping the perceived symptoms of mental illness (Kabir, Iliyasu, Abubakar, & Aliyu, 2004).

Stereotypes of violence and unpredictability also inform the indisposition to share a neighbourhood with persons with mental illness (Wolff, Pathare & Craig, 1996; DoH, 2003) as exemplified in 29.8% of the respondents who are opposed to care in community for people with mental illness. The case for deinstitutionalisation (community care) is further not helped by the public notion that people with psychotic disorders commit particularly violent crimes and constitute great danger for little children (Angermeyer & Matschinger, 2004). This is corroborated in this study with as many as over 4 in 5 people (Nigeria-based) and over two-thirds of the UK based samples indicating that they would not let people who recovered from mental illness take care of their children for a while. The finding compares with a Nigerian study of medical doctors where 4 in 5 would not accept a fully recovered psychiatric patient as a teacher of young children in a public school (Adewuya & Oguntade, 2007). It may equally explain why as many as a third of the respondents in this study endorsed social restrictiveness which expresses beliefs that people with mental illness are dangerous and are to be avoided or restricted. In a study that investigated secondary school teachers' attitude to mental illness in Ogun State, south-western Nigeria (Aghukwa, 2009b), 52% of teachers felt that persons with mental illness were unpredictable and would therefore not want such persons to serve in the police force. Over 68% of teachers would not want people who had been treated for mental illness to hold public jobs, 79% would not want them to serve as state ministers, 88% would not want them to be president, 84% would not want them to serve in the army while 69% would not want them to serve as medical doctors. This echoes the finding from the pilot study for the World Psychiatric Association (WPA) Programme "Open the Doors" where 72% of the respondents believed that persons with

schizophrenia could not work in regular jobs (Stuart & Arboleda-Florez, 2001a).

A great deal of stigmatisation is attached to mental illness in cultures such as the Igbo that emphasise saving face and bringing honour to the family (Leong & Lau, 2001). Thus, social distance can be stirred by associative stigma as was endorsed by 57.7% of the Nigeria-based and 47.1% of the UK-based respondents who would feel ashamed should a family member become mentally ill. An individual's behaviour is perceived to be a reflection of the extent to which the whole family upholds social values, norms, and expectations in traditionalist communitarian cultures (Erickson & Al-Timimi, 2001). Social reputation is therefore a crucial factor that should not be compromised by any shameful threats. Hence, while the social networks in these societies demonstrate strong disposition to providing support for family members when needed, they are also very intolerant of deviant behaviours. Thus, families can act as a protective shield against stress but can also be a major source of stress with their expectations of conformity.

Reflecting associative stigma, there is an Igbo proverb which translates that 'when someone is dancing weirdly (misbehaving), his kinsmen will abruptly develop itchy eyebrows' (scratching of which is metaphorical of covering their faces in shame). Goffman (1967) had argued that the face is a sacred thing hence everyday life's ritual actions centre on protecting it. Therefore, in the light of the prevalent negative view of mental illness, illness burden for persons with mental illness and their relatives (by association) will include the exerting psychological task of preserving or protecting 'face'. This could involve trying to conceal a relative's status or hospitalisation (Corrigan, 2014). The culture of shame and saving face leads to custodial care and tucking away of persons with mental illness thus disenfranchising them of social privileges and also going against their human rights. Family members experiencing associative stigma often feel alienated from neighbours and co-workers (Magliano et al., 2005; Perlick et al., 2007); people in a putative support network that might

assist the family in its goals.

In the Igbo society, many stereotypes of persons with mental illness are expressed in some pejorative or at best patronising anecdotes and deeds ascribed to 'the mad man'. For instance, to underscore the foolishness of 'the mad man', he is quoted to have said that 'if the man carelessly brandishing a machete behind him dares cut off his head, then, he would teach the man the lesson of his life.' Here, his folly is relayed in the fact that he could not 'teach someone a lesson of his life' after his head had been severed. Another saying ascribed to the mad man indicates that he has not got the sense of cause and effect. He was said to have ignited a fire that razed an entire estate but when he was confronted, he explains that he can only be held accountable for the particular spot where he ignited the fire; that the conflagration that later consumed the entire estate was none of his business. Yet, another stereotype presents the 'mad man' as lacking in the sense of proportionate action. He was said to have knocked on someone's door but got no response (presumably because the occupiers see him as a nuisance hence refusing to let him in). When it took so long and the door was not answered, he set the house on fire (to draw the attention of the occupants) and then he declared that the occupants of the house who were supposedly not at home would now 'inadvertently' appear. Then, to depict that persons with mental illness have no self-control (unpredictable), the 'mad man' was said to have declared that why they call him mad is that when he wants to say one thing, another thing will pop out of his mouth. A patronising stereotype of the mentally ill which people use to describe the uncertainties in their own lives is expressed in the proverb whereby the 'mad man' said that he is hastening to set out on his journey, not because his target destination is too far, but because of the possibilities of extra-curricular activities along the way, including a weird dance he could be performing in the market square.' Another proverb that patronizes the supposed wisdom of the 'mad man' holds that as he was passing by a church, he overheard the priest announce that he would be reading St. Paul's Letter to the Corinthians (a book in the Bible) to the congregation. The 'mad man' quickly dashed into the church to openly question the morality of reading someone's letter

to the public. He then threatened that as a punishment for the people's misdemeanor, he was going to set many houses in the community ablaze. This brought the church service to an abrupt end as people scurried home to protect their houses. Many of such pejorative sayings ascribed to the 'mad man' that stereotype persons with mental illness abound in the Igbo proverbial repertoire.

As earlier noted, explanatory models of causation adopted for mental illness can influence desire for social distance. Generally speaking, negative attitudes have been found towards patients whose illnesses are believed to be caused supernaturally (Mulatu, 1999). Supernatural causal attribution such as voodoo and witchcraft that associates mental illness with forces beyond the individual could elicit perception of strangeness, unpredictability and dangerousness (Aghukwa, 2009b; Minas, Gureje et al., 2006). It could lead to the indictment of the individual who may be seen as suffering a divine punishment (Audu et al., 2013). This has also been linked to the persistent dehumanising use of physical restraints on people with mental illness and their isolation by the society (Minas, Diatri & Pasung, 2008). The media industry which tends to be mostly concerned with acceptance, audience sentiments and ratings than the social responsibility of responsible framing is characteristically awash with exaggerated stereotypes of persons with mental illness that reinforce causal myths, prejudices, misconceptions, fears and anxieties in Nigeria. Atilola and Olayiwola (2011) found that the most common causes of mental illness as depicted in Nigerian movies were supernatural or preternatural forces (sorcery and enchantment by witches and wizards) and repercussions of evil deeds with effective treatment portrayed as arising mostly through spiritual means or traditional forms of care. The significant influence this could have in shaping public attitude in Nigeria is immediately evident in the Nigerian movie industry being the second largest in the world (UNESCO Institute for Statistics, 2009).

On the other hand, Dietrich and colleagues (2004) observed that endorsing biological factors as the cause of schizophrenia was associated with greater desire for social distance in a study of

Germany, Russia and Mongolia. Considering the condition as coming from a stable trait could lead to pessimism about prognosis and treatment outcome. There could equally be a concern that through 'perilous genes' the condition could be subsequently inflicted on offspring (Read, 2007) thus exacerbating dimensions of associative stigma experienced by relatives. In a previous study of this population, Ikwuka and colleagues (2014) had observed that a significant proportion made biogenetic causal attribution of mental illness with 86.8% endorsing heredity. This perhaps explains why as much as 81.8% of the Nigeria-based and 71.8% of the UK-resident samples indicated that they would not marry someone with mental illness. Biogenetic attributions could also fuel the stereotype of unpredictability since located in one's genes, the condition could be considered to be beyond the bearer's control. Moreover, attributing their condition to biochemical aberrations renders persons with mental illness as different which is a critical factor in the build-up to stigma. Hence, while the public has a right to the knowledge of such evidence-based causal factors as biogenetics, the attendant stigmatising side-effects also need to be taken into consideration. This concern was underscored in the findings of a meta-analysis of 33 reports on 16 population studies from around the world which showed a steady increase in perceiving mental illness as a treatable biological disorder, yet stigma about depression had remained constant during this time while that of schizophrenia has significantly worsened (Schomerus et al., 2012). Ethicists in the field of mental health need to explore ways of resolving this dilemma. Furthermore, as noted in Chapter One, the increasing endorsement of the use of illicit drugs and alcohol as causal agents in most Sub-Saharan African societies (which are linked to the moral failings on the part of the users) has been associated with stigmatising and negative attitude towards people with mental illness. Reinforced by the strong belief of many African cultures in retributive justice, when mental illness is associated with the recklessness of substance misuse, the sufferer could be seen as paying for his 'sins' and such beliefs deprives them the sympathy and understanding traditionally bestowed on the sick in African society.

With the recognition that no single individual is self-sufficient in the communalistic Igbo culture, the basic principle of the closely-knit kinship system is that of co-prosperity captured in the maxim 'onye aghala nwanne ya' (be your brother's keeper) (Oghojafor, Alaneme & Kuye, 2013). This system acts as the economic, social and medical units where strong members lend support to the weak (Onwuejeogwu, 1986). Such pro-community care philosophy is expected to facilitate the deinstitutionalisation and community approach of contemporary mental healthcare. It is thus incongruous that close to a third of the population (29.8%) opposed community care. This contradiction is accentuated when it is considered that although 70.2% and 96.7% expressed pro-community care and benevolent views respectively, an equally very high percentage (85.7%) endorsed primary and even secondary (52.4%) social distance thereby pitting practice against principle. This could be a reflection of the NIMBY (not in my backyard) attitude whereby people could support an ideology due to the social desirability factor but would not be open to the experience in practice due to entrenched aversion to the attitude object (Cowan, 2003; Leff & Warner, 2006). It corroborates the contradiction in the findings of Komiti and colleagues (2006) where the majority of participants (over 70%) believed that people in their respective communities would gossip about a person who had a mental illness, and that many people would be wary of someone who had been hospitalized for a mental illness yet most respondents believed that their respective communities would be supportive and caring towards someone with a mental illness. In a survey of mental health service providers in the UK National Health Service (NHS) and the voluntary sector, Repper and colleagues (1997) found that two-thirds had experienced NIMBY campaigns. The social desirability factor is reinforced in the Nigerian context by the fact that it is a culture where solidarity with the disabled is normative of the social value system.

An anti-community care stance could also be emblematic of the stress that home care of people with mental illness brings to families including: day-to-day practical constraints in social and work life, psychological distress engendered by the illness, problems in intra-family

relationships, severe economic hardships and heightened associative stigma (Wahl & Hannan, 1989, Corrigan et al. 2014) which could have more impact in an intrusive communitarian culture. Corroborating this, Perlick and colleagues (2004) found that greater family perceptions of devaluation and discrimination of both persons with the illness and their family members were associated with higher levels of burden. However, given that the solidarity of communitarian societies has been acclaimed as compensating for the deficient mental health infrastructure in these societies - it is considered to inform the consistent finding that schizophrenia has better prognosis in non-industrialized societies (Hopper & Wanderling, 2000; Harrison, Hopper, Craig et al., 2001), it is disturbing that the cohesive network is potentially undermined by anti-community care attitude, the domestic challenges notwithstanding. This fear is already being confirmed in the finding of a Nigerian study which looked at long-term social outcomes among a group of persons with schizophrenia who were receiving outpatient care. Contrary to the expectation that traditional family networks and supports would buffer these patients against drifting down in socioeconomic status, these patients continued to experience severe social disabilities in multiple domains (Gureje & Bamidele, 1999).

This study replicated the findings of a review of population studies (Angermeyer & Dietrich, 2006) which showed that lower education attainment, older age and less familiarity with mental illness were associated with lower tolerance of people with mental illness. However, it additionally found that males and those who belong to the Protestant religious denomination demonstrate more negative attitudes than the females and Catholics respectively. It also found that nurses demonstrated relatively more positive attitudes than the non-nursing groups (students, teachers and the general public). Education was associated with most of the attitude constructs with more education predicting the positive pro-community care attitude while less education predicted most of the negative attitudes: authoritarianism, social restrictiveness, primary and secondary social distance. This agrees with a study of northern Nigeria which found that literate respondents were seven times more likely to demonstrate positive attitudes towards people with

mental illness compared to illiterate respondents (Kabir et al., 2004). Papadopoulus and colleagues (2002) had observed that the most consistent predictor of stigma is knowledge level with higher knowledge scores correlating with decreased stigma. People with higher education have been found to be less discriminatory and restricting and supported social integration of persons with mental illness more compared to those with low education (Arvaniti et al., 2009). They were equally less moralistic and judgemental and had greater treatment optimism (Richmond & Forster, 2003).

The decisive role of education in shaping attitude was to the extent that levels of education were found to be associated with levels of attitudinal dispositions: respondents with postgraduate qualifications held less negative attributions towards persons with mental illness than those with first degree; those with first degree in turn were less stigmatizing than those with lower qualifications in aspects of responsibility, anger, dangerousness, fear and social distance (Aghukwa, 2010). Yet, stigmatising attitudes could be so entrenched that high levels of knowledge could co-exist with high levels of prejudice and negative stereotypes (Schulze, 2007). This is corroborated in the finding here whereby low education was only associated with secondary social distance which suggests that there was no significant difference between those with low education and those with high education in their pattern of high desire for primary social distance. Studies suggest that beyond mere formal education, positive attitude is enhanced more specifically with mental health education which disconfirms stereotypes with accurate conceptions and evidence-based insights (Corrigan & Penn, 1999; Gureje et al., 2006).

Mental health literacy is formally defined as information and beliefs about mental illness that aid in its recognition, management, and prevention (Jorm, 2012). It includes the extent to which information mastery and parallel skills lead to actual care seeking and participation. Corrigan and colleagues (2014) expatiated that it encompasses knowledge about preventing disorders, recognizing them when they develop, pursuing help when disorders become distressing, and using mental health first aid skills to support others in distress. Through the provision of

information and increased opportunity to gain more scientific knowledge about characteristics of illnesses, including causation, prevention and the possibility of effective treatments, mental health education challenges some negative traditional beliefs, introduces some evidence-based biomedical alternatives, enlightens the public to make more informed decisions about mental illness, challenges people with stigmatizing attitudes to reflect on their feelings and leads to some form of circumspection (Mulatu, 1999; Haghighat 2001; Monteith, 1996). For instance, it shows that:

1. Mental illness is indeed like any other illness as most people with mental illness retain many of their capacities (Sartorius, 2002). Some people with serious mental illness such as schizophrenia have demonstrated ability to live with recurring auditory hallucinations without distress, pursue a career, and enjoy a full family life (Ralph & Corrigan, 2005).
2. Mental disorders can be effectively treated or managed (WHO, 2001b; Kobau et al., 2010).
3. The public grossly overestimates dangerousness and violence of people with mental illness (Swanson et al., 2002; Swanson et al., 2006) and often inaccurately ascribes particularly heinous crimes such as mass shootings to mental illness (Corrigan & Watson, 2005).
4. It may "dehomogenize" perceptions of individuals with psychoses by emphasizing that violence is not a core attribute of the disorder as the potential for violence is oftentimes heightened by intervening co-morbid factors such as alcohol and drug abuse, treatment non-compliance, lack of knowledge about the condition, poverty, homelessness and a history of violence and criminality (Department of Health, 2001; Soyka, 2000; Aghukwa, 2009a).
5. It would show that not all serious mental illnesses lead to obvious or disruptive behaviour, for instance, patients with schizophrenia can have predominantly negative symptoms (Sadock & Sadock, 2007).
6. Mental disorders account for less violence in the society than do alcohol and drug abuse (Eronen et al., 1996; Brunton, 1997).
7. People with mental illness are actually more likely to be the victims rather than the perpetrators of violence (Department of Health, 2003); vagrants suffering with psychosis in

Nigeria experience repeated verbal, physical and sexual abuses (Aghukwa, 2009a, Adesomoju, 2013). They are exploited for money making e.g. used in circus shows and for rituals with some dying in the hands of the society.

Awareness of educational campaigns is associated with better recognition of mental illnesses (Jorm, Christensen, & Griffiths, 2006) and greater understanding of the benefits of treatments like counseling and medication (Jorm et al., 2005). The merits of mental health education is further demonstrated in the finding that medical students who had completed their course in psychiatry demonstrated more positive attitudes towards the social integration of patients than pro-clinical medical students who held attitudes similar to those of the general population (Ay, Save & Fidanoglu, 2006; Mukherjee et al., 2002). The United Kingdom's Time to Change initiative seeks to promote care and to challenge discrimination so that people with mental illness will have opportunities that are similar to those of everyone else. Awareness of Time to Change ranged between 38% and 64% and was associated with greater mental health literacy and less stigmatizing attitudes (Evans-Lacko et al., 2013). Targeting associative stigma (of mental health profession), an education programme delivered by a psychiatrist to high school students on mental health issues was found to increase the appreciation of practitioners and care seeking (Battaglia, Coverdale, & Bushong, 1990). Similarly, consistent with social learning theory, researchers suggest that teaching agents who are relatively similar to the pupil (patient) are likely to have the most impact hence peers can be especially potent teachers (Calhoun et al., 2010). Regular involvement of mental health service users in teaching sessions where possible is a positive way of reducing negative attitudes and of improving understanding of mental illness (Putman, 2008). This, in a way supports the consistent research finding that attitudes improve the most when theoretical knowledge is complemented with experiential knowledge i.e. with contact with persons with mental illnesses (Angermeyer, Matschinger & Corrigan, 2004; Björkman, Angelman & Jönsson, 2008; Rusch, Angermeyer, & Corrigan, 2005; Corrigan &

O'Shaughnessy, 2007).

Indeed, research suggests that theoretical knowledge without contact could increase social distance (Chou & Mak 1998). In a study of the British populace, Byrne (1997) found that despite more than half of the study sample having had a fair knowledge of mental illness, the majority held negative attitudes towards persons with mental illness. Similarly, population surveys in Germany in 1993 and 2001 showed an increase in mental health literacy but no change in the desire for social distance (Angermeyer, Holzinger, & Matschinger, 2009). Experimental studies indicate that among the available strategies, education, protest, and contact with a person with mental illness, the latter may be most effective in inducing change (Corrigan et al, 2002). A recent meta-analysis showed contact with somebody with mental illness yielding significantly better effects than education on attitudes about and behaviour intentions towards people with mental illness (Corrigan et al., 2012). Both personal and professional contacts with people with mental illnesses have been linked to reduced stigma. Findings indicate that people with more experiential information about mental illness such as relatives of people with schizophrenia are less prejudicial, less critical, more tolerant and desire less social distance from people with mental illness (Alexander & Link, 2003; Angermeyer, Matschinger, & Corrigan, 2004; Hannigan, 1999; Högberg et al., 2008). A large-scale survey of approximately 5,000 US adults revealed that those who knew someone with a mental illness or who ever had a mental illness themselves were less inclined to having negative stereotypes, and had more positive views regarding prognosis following treatment (Kobau et al., 2010). Huxley (1993) found that respondents who were less embarrassed by mental illness were more likely to know someone who is receiving help and treatment at the community facility. In a conservative, superstitious, morally and socially judgmental south-western Nigerian society, Odejide and Olatawura (1979) claimed that the effect of the day-to-day interaction of the psychiatric nurses with persons with mental illness so improved their attitude towards these persons to the

extent that many of the psychiatric nursing respondents held no objection to marrying ex-psychiatric patients.

Conversely, lack of experiential knowledge (either through personal experience or closeness to others who had experienced or were experiencing mental illness) was associated with more negative attitude including desire for social distance and social control (Brockington et al., 1993). This is corroborated in our study whereby those not familiar with person(s) with mental illness endorsed more authoritarian attitudes and desired more social distance from persons with mental illness than those familiar with person(s) with mental illness. Contact entails strategic interactions between people with lived experience of mental illness and targeted members of the public (Couture & Penn, 2003). The interaction mediated by contact violates the stereotype held by those without mental disorders. Contact theory proposes that contact decreases negative attitudes through cognitive individuation especially when the contact is auspicious – personal, intensive, extensive, equal, voluntary and within a meaningful supportive context (Weller & Grunes 1988; Corrigan & Penn, 1999; Penny, Kasar & Sinay, 2000; Wallach, 2004). Real-life interaction is more rewarding than virtual or arranged meetings (Sigelman & Welch, 1993) and contact should be with a representative member of the population such as with somebody who may still grapple with residual symptoms but who is fairly well integrated e.g. capable of independent living, rather than with an exceptional member of the population e.g. a perfectly cured person (Des-forges et al., 1991; Corrigan & Penn, 1999; Angermeyer & Matschinger, 1997). Contact with an ‘atypical’ member may be sub-typed as unusual and sub-typing insulates the broader stereotype (Kunda & Oleson, 1995, 1997). Thus, the nature of contact is a critical factor in the workability of the contact theory. A brief exposure can be detrimental and could increase social restrictiveness (Wallach, 2004). Keane (1991) suggested that brief contact with people with chronic severe mental illness contributes to a sense of hopelessness in students. As Kermode and colleagues (2009) observed, perception of

dangerousness may be more difficult to address if it is generated by personal experience with people who are in crisis situation with their condition. This agrees with Corrigan and colleague's (2005) submission that contact can worsen a stereotype if the type of person interacted with reinforces it. Some negative experiences such as a difficult or distant family relationship, a troubled marriage to a person with mental illness, a threatening public encounter with a stranger who appears mentally ill or negative experiences in the workplace would likely have no positive impact or have a negative one upon stigmatizing attitudes (Alexander & Link, 2003). Education can however play a dousing role in explaining peculiar crises situations and their possible co-morbid risk factors thus underscoring the complementarities of contact and education in combating negative attitude. As observed with education, the scale of contact is positively associated with improvement of attitude. This was evident among physicians whereby General Practitioners with over 10 years of experience demonstrated more favourable and more decisive views of patients with mental illness than the House Officers (Khoweiled, 2005). Afana and colleagues (2000) equally showed in their study exploring the attitudes of 166 Palestine primary health care professionals that older professionals demonstrated more emotional and tolerant attitudes. Ndeti and colleagues (2012) found that older nurses and older doctors in the profession had less stigmatising attitudes which may result from more clinical exposure and awareness in the course of their practice and experience.

Older age was associated with more social restrictiveness, less pro-community care and less benevolent attitude toward people with mental illness. It was also associated with more desire for secondary social distance. These findings agree with studies that identify the old with generally more negative attitudes (Papadopoulos, Leavey & Vincent, 2002; Riedel-Heller, Matschinger & Angermeyer, 2005; Shulman & Adams, 2002). As the custodians of tradition in the study context, the old are associated with more pre-scientific and supernatural causal views which have been linked with negative attitudes towards mental illness (Gureje et al., 2006; Song et al., 2005; Adewuya & Makanjuola, 2008). Furthermore,

considered to be more concerned about social equilibrium, the old would be more averse to situations perceived to be capable of being disruptive (Stuart & Arbodella-Florez, 2001b). However, there was the atypical finding whereby the young demonstrated more authoritarianism than the old. This relates to the observation that the young are more fearful of and more likely to associate people with mental health problems with violence (Crisp et al., 2000; Pinfold et al., 2003). Kobau and colleagues (2010) also found that young adults aged 18–24 years were more inclined toward negative stereotypes and were more pessimistic about treatment and prognosis which may dissuade them from seeking treatment in times of need. Stigma is under-researched in adolescents, covering less than 4% of stigma research (Link et al., 2004), yet this group is less likely to receive appropriate care (Department of Health and Human Services, 1999). Stigma reduction during the adolescent years is important for early detection and early treatment, and increasing adolescents' comfort in discussing mental disorders (Pinto-Foltz & Logsdon, 2009). Furthermore, the finding supports the suggestion that when broken down, some aspects of stigmatising attitudes may be more pronounced with a particular group (Hannigan, 1999). Hence anti-stigma campaigns could be more effective with targeted than general campaigns.

The males endorsed more social restrictiveness and were less supportive of community care than the females. This agrees with many research findings indicating that males relatively demonstrate more negative attitudes towards mental illness than females (Kobau et al., 2010; Jorm & Wright, 2008; Chandra & Minkovitz, 2006; Marie & Miles, 2008; Phelan & Basow, 2007). Men's negative attitudes could result from traditional masculine social roles which disapprove of expressiveness in illness behaviour (Addis & Mahalik, 2003; Moller-Leimkuhler, 2002; see also Chapter four). Males are equally far less knowledgeable about health in general (Courtenay, 2000) and mental health in particular (Cotton et al., 2006). On the other hand, gender differences in relationship style could provide an insight into why females demonstrate more positive attitudes to people with mental illness. Maccoby (1990) had suggested that

females' social interaction patterns are of the 'enabling style' that fosters greater equality and intimacy and keeps the interaction continuing, whereas males tend to exhibit the 'constructing style' to inhibit their partners or cause the partner to withdraw, shorten the interaction, or bring it to an end. Consequently, females had been found to be more willing to foster social interaction with persons with mental illness and support their integration in schools and community (Antonak & Harth, 1994; Gash & Coffey, 1995). However, Dessoki and Hifnawy (2009) suggest that females tend to be more negative towards mental illness in cultures that discriminate against women. In these cultures, women may be the greater sufferers from the stigma of mental illness with regard to reduced marital opportunities and increased risk of divorce in an existing marriage should the condition become public. Supporting this notion is the finding that higher number of men receive hospital treatment for schizophrenia in Morocco which suggests that stigma is greater for women, as few women come forward for treatment (Kadri, Manoudi, Berrada & Moussaoui, 2004).

Controversy remains over how and to what extent religiosity and denominational affiliation influence attitudes and behaviour on social issues. Denominationalism is however associated with conservatism in some aspects of socio-ethical judgements with Evangelical Protestants and Catholics, for instance, being more pro-family and pro-life than mainstream Protestants (Bradley & Michael, 1987). This seems a plausible ideological background to the finding in this study that Protestants desired both primary and secondary social distance from people with mental illness more than the Catholics. Catholic beliefs are based on a high principle of right to life (Jelen, 1984) and therefore less subject to the challenges of extenuating circumstances including disability. Furthermore, a previous study of this population (Ikwuka et al., 2014) found that compared to the Catholics, mainstream Protestants were more supernatural in their causal attribution for mental illness which is associated with more negative attitudes. It is suggested that the more independent Protestant denomination tends to be more indigenised than the West-mediated *Roman Catholic Church* (Meyer, 2004).

More than half of the nurses endorsed authoritarianism and primary social distance comparable to the non-nursing groups (students, teachers and the general public). This is a disturbing finding given that nurses are major providers of hospital care. Studies have noted the adverse impact of negative attitudes and incompetence of many nurses in the provision of care (Sharrock & Happell, 2002). In one study, nurses were less optimistic about treatment outcomes of mental illness than the public (Hugo, 2001). Clinical observation bias has been cited as one reason why professionals especially nurses develop negative attitudes towards persons with mental illness (Grausgruber, et al., 2007; Hugo, 2001). This suggests that staffs in in-patient clinical services often see chronic patients with poorer prognosis as people with better outcomes would present more as out-patients, away from the regular view of staffs working in such environments. Constant encounter with chronic patients could therefore lead to therapeutic pessimism and a biased view of consumers' potential. This agrees with Bailey (1998) who found a predominantly negative experience of nurses' care for psychiatric patients in general wards owing to lack of positive feedback. Negative attitudes may also stem from negative professional experience with chronic mentally ill clients especially from patients suffering from paranoid schizophrenia who could display aggressive behaviour that could lead to distancing behaviour from health workers.

Among the health workers, nurses have been noted as most prone to suffer violence in the hands of patients (Rippon 2000; Cooper & Swanson, 2002; Whittington & Higgins, 2002). Overall however, negative professional attitudes stem from a lack of knowledge, frustration and a sense of inadequacy in handling the difficulties posed by this client group (Gafoor & Rassool, 1998; Thomas, 1995). Studies highlight the importance of training programmes to improve the practical and theoretical knowledge of nurses (Lowe, Bond, Spokes, & Wellman, 2002; Needham et al. 2002). General nurses studied by Reed and Fitzgerald (2005) who disliked and avoided caring for patients with mental illness because they felt inadequate displayed positive attitudes when given support. Thus, training improves confidence and

increases treatment optimism (McConachie & Whitford, 2009; Gerace, Hughes & Spunt, 1995; Hagemaster et al., 1993). The relatively better training of nurses unarguably explains the promising finding that the nurses displayed significantly more of the positive (pro-Community care) and less of all the negative (Authoritarianism, Social Restrictiveness, Primary and Secondary Social Distance) attitudes compared to the non-nursing groups. This further underscores the importance of mental health education in combating negative attitude. However, comparing the attitudes of general nurses with those of psychiatric nurses could help to further substantiate the merits of training and the contact theory.

Teachers not only did not differ from the general public in their pattern of negative attitudes across the constructs but were actually less pro-community care. This reflects the finding of a Nigerian survey (Aghukwa, 2009b) whereby 4 in 5 teachers felt that psychiatric inpatients should be surrounded by high walls and guards. This suggests that teachers are no better than the parents and their school-going children in their understanding of mental illness. It is a disturbing finding given the critical role of teachers in the attitude formation of pupils including some that may be experiencing mental illness. It goes to show that in the war against stigma, being merely educated (which does not easily eradicate culturally enshrined beliefs, Ikwuka et al., 2014; Adewuya & Oguntade, 2007) is not just enough. There is a specific need for mental health education that addresses mental illness stigma.

The UK based respondents displayed significantly less negative attitudes compared with the Nigeria based group with regard to desire for social distance both at the primary and the secondary levels of relationships. A proximate methodological explanation could link this to the UK based sample having significantly more people with high education than the Nigeria based sample. And, as the study already showed, more education is associated with lesser negative attitude. However, it is equally to be expected that social conditioning (acculturation) could be a factor whereby the experience of the host (UK) culture with more

developed and open health care system, mental health charities and campaigns for the rights of the mentally ill would have influenced the attitudes of the UK-based respondents. Yet, that close to two-thirds (63.6%) and 41.2% of this (UK-based) sample still endorsed primary and secondary social distance respectively gives a cause for concern. There is the potential that this immigrant population could treat persons with mental illness with prejudice in a culture that is less accepting of such discriminatory attitudes and this could lead to conflict. Moreover, it could have implication for their mental health care as immigrants in a Western host culture. For instance, it could lead to self-stigmatisation when suffering from mental illness and stigmatisation of psychiatric services. These in turn could lead to poor help-seeking behaviour. Secondly, when it leads to lowered self-esteem, it could further impact negatively on adjustment which is already potentially threatened by migrant status. In a UK study, Wolff and colleagues (1996) noted that minority ethnic groups are more likely to hold negative attitudes towards mental illness than white British-born. Explaining the difference, the authors suggested that minority ethnic respondents were more likely than the white UK-born group to object to an educational campaign. However, drawing insights from studies that investigated the causal mechanism that mediated the disparities in school attainments of ethnic groups, possible explanation for minority anti-education attitude could include language barrier (Maughan, 2005), socio-economic constraints (Walters, 2001), the atmosphere of mutual mistrust between the system and the ethnic minorities (Gillborn & Gipps, 1996) but most importantly, as the foregoing suggests, the carried-over cultural background of the immigrants that potentially fuels stigmatising attitudes.

2.4.1 Conclusion

This study revealed pervasive negative attitudes towards people with mental illness with a considerable endorsement of the negative attitude constructs. Moreover, considering that the degree of social distance established by the study was as desired from those already cured of mental illness, it should be expected that those living with the condition will experience even

greater negative attitudes. Authoritarianism which sees persons with mental illness as different and endorsed by over four in five of the population was considered to be largely informed by the collectivist nature of the culture that stresses conformity thereby making it easy to isolate 'a deviant'. Aesthetics was also considered a factor in the isolation of the 'unkempt psychotic vagrant'. Social distance endorsed by more than half of the population and social restrictiveness endorsed by over a third are mostly informed by stereotypes of dangerousness and unpredictability. These are exacerbated by a cultural perspective that judges the gravity of psychiatric illness on behavioural grounds. Close to a third of the population demonstrated anti-Community care attitude. Given that more than half of the population also demonstrated desire for social distance, these constitute a contradiction in this traditionally communitarian and predominantly Christian culture that prides in being one's brother's keeper. This could be emblematic of the distress that home care of people with mental illness engenders. However, more research is necessary to help further unravel this contradiction.

Mental illness is among the conditions associated with the most disabilities and the burden of the disease is compounded by stigma. Combating stigma could be formidable as stereotypes are difficult to disconfirm once developed. It is therefore important that the study highlighted some of the mechanisms that mediate or reinforce the negative attitudes which include culture, level of education, degree of familiarity/contact with the mentally ill and religious affiliation. This could help in targeted interventions as omnibus approach to stigma change would likely not be effective and might even yield unintended results like exacerbating other forms of discrimination. A multidimensional approach based on evidence-based targeted interventions should include: mental health education with experiential content, advocacy for social policies and legislations that promote integration, cultural competency in care, and the engagement of the social network. Anti-stigma efforts also need to target providers at pre-service education, in-service training, and ongoing practice, enhancing their skills to engage people with psychiatric challenges. Identifying the origin of stigmatizing attitudes in childhood or

adolescence will help early interventions. Periodic longitudinal studies could also help to determine the trends in public attitudes towards mental illness and in the assessment of the impact of the interventions that have been introduced.

As earlier noted, the prevailing community approach to care with the acknowledged role of the community in the prevention and care of the mentally handicapped as the most appropriate basis for the development of mental health programmes (Dessoki & Hifnawy, 2009) heightens the significance of determining the public attitude to mental illness. The practical extent to which attitudes impact help-seeking will further unravel in subsequent chapters that examine preferred treatment pathways and barriers to help-seeking.

Chapter Three (Study 3)

Pathways to mental healthcare

3.1 Introduction

3.1.1 Theoretical Framework

Healthcare seeking behaviour is conceptualised as a sequence of remedial actions taken to rectify perceived ill-health (Ahmed, Adams, Chowdhury & Bhuiya, 2000). Studies suggest that pathways to healthcare are not random; while clinical factors such as symptom severity provide the impetus to the pathway, the decision to seek help and the selection of a help provider are structured by the convergence of personal, developmental, psychosocial, cultural, systemic and socio-economic factors (Cauce et al., 2002; Rogler & Cortes, 1993). From a cognitive theory framework, three identifiable stages characterise the help-seeking pathway: defining the problem, deciding whether to seek help, and finding a source of support (Liang, Goodman, Tummala-Narra & Weintraub, 2005). Research demonstrates that pathways to psychiatric care largely follow three models reflecting the cultural and socio-economic characteristics of a group (Sorketti, Zuraida & Habil, 2013).

3.1.2 Pathway Typologies

3.1.2.1 Mainstream (Psychiatric) Pathway

The first pathway, which is typical of main stream (Western) psychiatry, is dominated by the biomedical explanation for mental illness with emphasis on the diagnosis of symptoms which are treated primarily through medical interventions. Here, General Practitioners (GPs) act as gatekeepers to psychiatric services. Following this pathway, the median time taken to reach specialist mental health services in Australia was 6 months, with a significantly shorter time for patients with psychotic disorders (Steel et al., 2006). However, the referral source for the greatest proportion of patients in this system was emergency services (Anderson, Fuhrer & Malla, 2010).

3.1.2.2 General Medical Pathway

In the second pathway, patients could see any care provider of their choice including having direct access to mental health professionals. This model is observable in parts of Asia such as Japan (Fujisawa et al, 2008) and Eastern Europe where more than a third of patients (32% - 46%) took a direct route to specialist psychiatric care in Belgrade, Bucharest, Iasi, Strumica and Zagreb (Gater et al., 2005). Direct access to mental health professionals makes for timely intervention thereby shortening the duration of untreated illness especially in cases with the potential to escalate beyond GPs' resolution. However, it could equally undermine the important gate-keeping roles of GPs that filter the care pathway thereby ensuring more cost-effective deployment of specialist services.

3.1.2.3 The 'Free Market' Model

Traditional and faith (alternative) healers play important roles alongside orthodox professionals in the third pathway that could be described as 'free market' model of care and is mostly observable in traditionalist (collectivist) societies of the developing world. Lay cultural beliefs guide help-seeking in this model and a network of personal contacts are often exhausted before contact is made with professional services. Consulting traditional or faith healers is predicated on the entrenched cultural and religious background of the people which engenders supernatural causal attribution for mental illness (cf. Chapter One) and potentially discounts the effectiveness of orthodox psychiatry. Available studies on the pathways to mental healthcare in different regions of Nigeria, Africa and other developing societies beyond Africa show that the majority of respondents consulted traditional/spiritual healers before their eventual arrival at the psychiatric facility.

A study conducted in Akure, south-western Nigeria found that about 70% of patients have been treated by spiritual healers and 43% by traditional healers before presenting at a conventional psychiatric facility (Agara & Makanjuola, 2006). In a more recent study of south-western Nigeria (Adeosun et al., 2013), the majority of patients (69%) consulted spiritual or traditional

healers as the first contact in the process of seeking care for mental illness while psychiatrists were the first contact for only 17.4% of the patients with 13.8% having previously consulted a non-psychiatric physician or General Practitioner. In a qualitative study of Uganda (East Africa), Nsereko and colleagues (2011) found that traditional healers were usually the first source of care people sought when faced with mental health problems, and frequently the only source of care sought. In a study of Ethiopian sample (North-east Africa), Bekele and colleagues (2009) found that 41% of patients directly contacted the mental hospital while the rest (59%) sought care from up to four different caregivers before arriving at the psychiatric hospital with 30.9% of these consulting spiritual care providers. The median delay between onset of illness and arrival at the psychiatric hospital was 38 weeks. A qualitative study of KwaZulu – Natal (South Africa) found that traditional and faith healers were the first port of call leading to delays in reaching specialised services (Mkize & Uys, 2004).

While service users initiated contact with traditional/spiritual healers within one month after the onset of symptoms in a south-western Nigerian survey, conventional psychiatric facilities were not consulted until about nine months later (Adeosun et al., 2013). A study of northern Nigeria found that none of the patients first consulted a psychiatrist in the care pathway and the mean length of illness before psychiatric evaluation was 4.5 years (Aghukwa, 2012). A study of Malayan psychiatric patients showed that based on their beliefs and those of their relatives and friends, two-thirds had consulted traditional healers (bomoh) for treatment only to consult a psychiatrist after a significant delay (Razali & Najib, 2000). In Turkey, the Islamic belief system intermingled with Shamanistic elements is reflected in the explanations advanced for mental disorders and in the help-seeking behaviours and manifestly leads to occasional practices like magic, enhancement, and visiting sacred shrines and tombs (Güleç et al., 2006; Yaşan & Gürgen, 2004). However, though 19.5% of respondents indicated that they would seek spiritual healing for schizophrenia and 14.8% said they would do nothing, as much as 40% endorsed psychiatric consultation to be the single most important

management step in a survey of a Pakistani sample (Zafar et al., 2008). This reflects the fact that non-Western societies also endorse modern western medical care for mental health problems in addition to the existing alternative methods.

Consideration of a variety of treatment options in this model is mostly informed by the fact that often multiple and sometimes conflicting beliefs are held as potential causes of illnesses (Ikwuka et al., 2014). This 'cognitive tolerance' (MacLachlan, 1997) is reinforced by the entrenched cultural and religious background of the people which engenders a holistic conception of human beings with the health and well-being of people attributable to immediate or distant spiritual, social, and natural factors (Westerlund, 1989; Aghukwa, 2012). The implication is that help-seeking stages are not necessarily sequential or discrete and it is not unusual for individuals to describe their getting help for a mental health problem as simply 'muddling through' (Cauce et al., 2002). A help-seeking process can start in any one of traditional, faith or orthodox psychiatric healer and end in another with the possibility of having passed through the second in the triad. Rogler and Hollingshead (1985) cited an incident in Puerto Rico whereby a man prone to violent eruptions was taken to a psychiatrist by relatives so that he could be tranquilized and then taken to a "genuine" therapist, a spiritualist medium. Similarly, that about one in five clients today drop out of therapy (Swift & Greenberg, 2012) may signify a change in pathway direction towards other sources of help. Crisis occurs when previous coping methods can no longer solve problems and in such situations, people are more receptive and apt to change (Donnelly, 2005). Problems could also be redefined over time and there could be such contingencies as the intervention of the police (negative contact) or emergency services. Thus, the correspondence between need and action is neither direct nor reliable and the cessation of the pathway needs not empirically coincide with the termination of the problem. However, pathways are travelled ultimately in hope of attaining secure services which may be reached in formal or informal settings.

3.1.2.3.1 Spiritual Pathway (Faith Healers)

Alternative institutional care in Nigeria can be categorized into two types; syncretic religious organizations (faith healers) and traditional native doctors (dibia in Igbo). The two models often share a common recourse to the supernatural for both diagnosis and healing - faith healers to the Judeo-Christian God (or Allah for Muslims) and traditional healers mostly to pantheon of gods or ancestors. However, there are also significant peculiarities. Faith (spiritual) healers had mostly belonged to the African Initiated Churches (AIC) though many have sprung up from the mainline Catholic and Protestant churches in recent times. They adopt Christian or an integration of Christian and traditional healing methods which include religious rituals such as: prayers, fasting, prophesying, exorcism, deliverance sessions, use of sacramentals (holy water, holy oils, burning of incense etc), offering of sacrifices, and the syncretic use of herbal and other concoctions by some of the practitioners (Oyegbile, 2009; Lawani, 2008). The therapeutic process could involve: confinement, flogging, chaining, counselling, home visitation of patients to help them get rid of certain diabolical items which the healer claims had been used to bewitch the patient.

Faith healers usually mystify their proceedings (the art of *anwansi* in the Igbo therapeutic practice) with the aim of inspiring awe in their clients which often works to dispose the clients more confidently towards the therapeutic process. However, the process (anwansi) could also be manipulative - exploited to achieve influence over gullible clients for questionable ends even if it entails using 'spiritual' blackmail on them. For instance, a pastor could prophesy impending doom or fortune over the client which only he (the pastor) could forestall or mediate as applicable. In this way, such 'pastors' secure their trade which thrives in their followers having perpetual recourse to them while they extort pecuniary gains from the clients even at the risk of worsening client's condition and possible death. In his play *The Trials of Brother Jero* which is reminiscent of *The Pardoner's Tale* by Geoffrey Chaucer, the Nigerian Noble Laureate for Literature Wole Soyinka illustrated this scheme. The

dubious Prophet Jero deploys his mastery of manipulation to keep his followers subservient because he understands what they long for – wellbeing (money, social status, health and power) and convinces them that they will soon be able to fulfill these desires. His followers were gullible enough to believe him.

Though the art of *anwansi* raises ethical questions especially because of the possible abuses, it nonetheless underscores the need for therapists to demonstrate competence in their field which is necessary to inspire the client's confidence in the therapeutic process. Faith healers in the region also provide social and material support for the usually destitute sufferers of serious mental illness many of whom live with psychosis as vagrants. They place themselves at the meeting point between what they refer to as the backward and outdated traditional healers and the modern, scientifically based Western medicine (Freeman & Motsei, 1992). The significance of their practice in south-eastern Nigeria is immediately evident in 95% of the population being practicing Christians for whom their faith has become a way of life. Studies have also helped identify the spiritual meaning to mental health trauma which has helped transform users' experiences positively (Clarke, 2001; Mental Health Foundation, 2002). The significance of the religious and spiritual experiences of users in offering comfort and support for mental health problems and during treatment in mental health institutions has also been acknowledged (Fallot, 2001; Harrison, Koenig, Hays et al. 2001).

3.1.2.3.2 Traditional Pathway

The WHO (2002) defines traditional medicine as the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses. Like the spiritual model of care, the traditional model could involve medical and non-medical procedures including complexity of rituals such as: divination, offering of supplications or sacrifices to appease the ancestors (who could have inflicted the affliction), exorcism and use of charms and

incantations/invocations to ward off evil spirits. It could also involve the use of herbal medications and other concoctions. The therapeutic procedure could also entail confinement, flogging, chaining and counseling. Traditional healers utter incantations to potentiate medicines which are regarded as possessing their own "life force" and not just the chemical activity of constituent substances (Nwokocha, 2010). Diviners claim access to the supernatural realm which enables them to unravel the cause of illness and misfortune. Hence, while patients went to hospital mostly to have their illness cured, clients of traditional healers consult them for both the cure and explanation of the cause of their illness. The traditional healers also deploy the art of *anwansi* (mystification of their art) in the therapeutic process to inspire awe and earn the confidence of their clients. They often confirm the beliefs of patients and diagnosis are normally tailored to meet the expectations of the native clientele (Edwards et al., 1983; Sorsdahl et al., 2009). The popularity of traditional healers is further reinforced by their being additionally available and accessible in the community.

3.1.2.3.2.1 The social network

The intervention of the social network is also a critical factor in help-seeking behaviour especially in traditionalist (communitarian) systems (Barksdale & Molock, 2008; Angermeyer, Matschinger, & Riedel-Heller, 2001). The social network has been referred to as network of potential consultants (Angermeyer, Matschinger, & Riedel-Heller, 2001). It consists of multiple spheres of influence, each defined by its proximity to the individual; from the intimate and informal confines of the nuclear family through successively more select, distant, and authoritative laymen, until the professional is possibly reached (Rogler, 1993; Cauce et al., 2002). These influence the conceptualization and interpretation of psychopathological symptoms, stereotypes regarding the effectiveness of given care pathways, coping mechanisms and the ultimate decision on which caregiver to consult (Sorketti, Zuraida & Habil, 2013). Cauce and colleagues (2002) illustrate the dynamics of the social network with an African American mother of a seemingly depressed child who may consult

her own mother, her sister, her best friend, and the family priest to get their opinions on whether her child's problem is serious or worthy of attention. Each conversation may alternately increase or decrease her level of worry and corresponding commitment to seek help. If this round of consultation leads to the conviction to seek help, another round of consultation might ensue regarding what type of help that should be sought. Supporting this illustration, a study that explored the perceived norms and mental health help-seeking among African American College Students found that family influence uniquely predicted help-seeking intentions (Barksdale & Molock, 2008).

In communitarian cultures such as the Igbo culture, the family forms the basic unit of the social network and is the customary starting point of the pathway (Mackenzie, Gekoski & Knox, 2006; Logan & King, 2001; Nobles & Sciarra, 2000). The decision to seek help for psychological problems and the pathway to be explored is a collaborative family effort which usually crystallises from a deliberative decision of the adult family members with possible input from close associates including extended family members and friends as the occasion might allow (Al-Issa, 2000; Al-Krenawi & Graham, 1999). Relatives equally take it as their responsibility to prompt a member who demonstrates the need for help to seek help urgently in these societies. While studies conducted in Western cultures cautiously noted that attitude towards mental health services is 'partially' transmitted by family and friends (Angermeyer, Matschinger, & Reidel-Heller, 2001; Rickwood & Braithwaite, 1994), the decisive influence of the social network in collectivist cultures was exemplified in the finding that relatives initiated contact for the first treatment option in nearly 91% of cases in a study of Igbo sample whereas only 9% was initiated by the patients themselves (Aniebue & Ekwueme, 2009). A study that investigated care-seeking of psychiatric patients in northern Nigeria found that for over 4 in 5 of patients, contact with the first healer was initiated by the patients' relatives with only 3% of first contacts being initiated by patients (Aghukwa, 2012). Another study that investigated pathways to mental healthcare in northern Nigerian noted that sources of

information about available mental health facilities mostly came from community members and neighbours (65%) ahead of the mass media (15%) (Abdulmalik, 2012).

Cameron and colleagues (1993) found that 50% of those who sought medical services were prompted to go by a significant other. They also found that 92% of those who sought medical care (as opposed to 61% of those who did not) talked to at least one person about their problem before seeking professional medical help. These corroborate the suggestion by Cauce and colleagues (2002) that social networks may have their greatest impact at the point of service selection in the help-seeking process because of their strong influence on real decisions about treatment. It has been noted that if the need to go for mental health assessment and treatment is strongly supported by the family it does often work (Thornicroft, 2008). Hence, while social networking is only being encouraged in the West e.g. encouraging spouses to come to an initial appointment (Cusack, Deane, Wilson, & Ciarrochi, 2004) and calls are made for the creation of social advocacy groups that include partners, friends, family, and individuals from the community (Byrne, 2000), this is normative in collectivist cultures.

Social networks can influence the help-seeking behaviour of people suffering from mental disorder as a communication system by providing information and links, as a reference system by formulating normative expectations, and as a support system by providing care, reporting symptoms and helping patients cope with the psychosocial stressors especially where the healthcare system is less developed (Angermeyer, Matschinger & Riedel-Heller, 2001; Wong, 2007a,b; Bergner et al. 2008). In traditionalist communitarian cultures, the family cares for both the clients who are mostly outpatients (due to lack of admission facilities) and those that are admitted in care. The latter is reinforced by a care policy in Nigeria whereby one close relative must stay with a patient on admission (Aniebue & Ekwueme, 2009). Living alone at the time of onset and a lack of family involvement on the pathway to care increased the likelihood of taking a negative care pathway (Anderson, Fuhrer & Malla, 2010; Morgan et al. 2005). Donnelly (1992) observed that a family oriented psycho-educational approach was more

effective in treating immigrants from collectivist cultures in an individualistic Western environment than an individual modality alone. Family collaboration is likely to increase the psychiatric clients' treatment adherence and follow-up in the community in these cultures. Hsu (2003) had indicated that a family oriented psycho-educational approach could enlighten family care-givers in such areas as medication regimens, especially monitoring medication in order to prevent relapses.

Boerner (2009) exemplified the importance of traditional support of family friends with the story of Nancy Sharby, a mother of two children that suffer from bipolar disorder in the US. She could not have her children treated because their insurance plan did not cover mental health since 'the brain is the only organ in the body that requires its own insurance policy'. Nancy had to fall back on friends and family network support system. She confessed "if I didn't know the people I know, I never would have gotten the services I did for my kids.... Both my kids have told me that if I didn't do what I did for them, they'd be dead or psychotic by now, because they were very, very sick. You can't advocate for yourself when you're psychotic. But even if you're not psychotic, you still can't fight for yourself if you don't know the system.... I have friends who are psychiatric nurses, social workers, insurance brokers, and if I didn't have all those pieces, I couldn't have gotten the services I did for my kids."

In a study by Dow and Woolley (2012), Albanian respondents described the close-knit nature of the family as the most important thing in life and the main source of help and support for coping with various problems, including mental health issues. Family bonds and obligations were described as so strong that family members were reportedly willing to make sacrifices such as deciding not to get married or to quit jobs to serve the sick loved ones. The family was described as the first, and sometimes the only place for seeking help especially when experiencing mental health problems. Family members can neglect their own mental health as they carry the burden of caring for a family member with mental health problems. In collectivist cultures, people do not distinguish their own interests from those of the group and perceive

the self as intertwined and bound to others. While Western cultural values emphasise individualism, success, competition, and intellectualism, values that may inhibit Westerners from turning to the informal network for help in fear that it may be interpreted as a sign of weakness (Tzahr-Rubin, 2003), family and primary group relations are central and most valued in collectivist cultures with emphasis on the collective over the individual. This enables mutual aid and reliance on informal help over professional mental health facilities which from the perspective of the communitarian settings have the potential to isolate the patient.

3.1.3 Rationale for study and aims

Traditional and faith healers may play an important role in addressing mental health needs by offering culturally appropriate treatment. However, these pathways are associated with the longest delay in reaching specialized services hence longer duration of untreated illness (Burns, Ihazbhay & Emsley, 2011; Güner-Küçükkaya & Ünal, 2012). Depicting them as more tortuous pathways, a Nigerian study (Adeosun et al., 2013) found that patients who first consulted general practitioners presented to an average of one care provider before presenting to mental health professionals while those that first consulted traditional or religious healers saw an average of about six care providers before presenting to mental health professionals. Delay is escalated by the lack of referral skills on the part of traditional and spiritual care providers which may be fuelled by the conception of referral as admission of incompetence. Furthermore, though limited social networks predicted the restricted utilisation of mental health resources in a study (Bonin, Fournier, & Blais, 2007), research also hints at the irony of the inhibitory influence of tightly meshed social networks that can insulate individuals from linking up with health facilities (Birkel & Reppucci, 1983).

The first line of care experienced by person(s) with mental illness constitutes the most important stage of the psychiatric care pathway as delays in the initiation of appropriate treatment are associated with worse clinical and social outcomes including; the exacerbation of psychotic

symptoms, poor response to treatment, and poor quality of life in patients with schizophrenia (Adeosun et al., 2013). Investigating pathways to mental healthcare would highlight the popular beliefs about mental illness, the nature of accessible services and the choices that might have critical implications for eventual outcome. In a rapidly globalizing world, it would further guide health professionals and therapists working in multi-cultural settings, helping them to situate their patients more contextually for greater therapeutic alliances. However, most research on pathways to mental healthcare and the limited research from Nigeria deal with clinical samples at conventional mental healthcare facilities where the customary pathway culminates. This creates a gap in knowledge since the pathways taken by the majority of distressed persons do not lead to or end at such formal care centres (Ware, Manning, Duan, Wells & Newhouse, 1984). This study aims to plug this gap in knowledge by exploring the preferred pathways to care by a non-clinical cross-section of the south-eastern Nigerian population (Nigeria vs. UK-based).

The aims of this segment of the research include:

1. To determine the treatment options the Igbo people in Nigeria and those in the UK prefer among the traditional, spiritual and conventional psychiatric treatments.
2. To determine the demographic predictors of preference for given treatment pathways.
3. To compare preferred pathway choices across demographic groups
4. To consider the determinant factors in the preference of given pathways.
5. To consider the merits and demerits of treatment pathways and propose a way forward.
6. To develop materials for a new measure of preferred treatment pathways for mental illness.

An inclusive view of pathways to mental healthcare with complete mapping of care providers in the community is necessary for the planning of mental health services and the eventual evolution of a model of care that would be more responsive to the cultural characteristics and contextual peculiarities of this under-researched and under-served region. The additional survey of UK-based Igbo sample is predicated on the consideration that the pathway preferences of

immigrants from traditionalist collectivist cultures would have critical implications for the eventual outcome in a Western industrialized host culture. The comparison of the two samples could additionally highlight the influence of migration on pathway choices. There are three parts to the study; Study 3a is the development of the quantitative instrument used in the rest of the study, Study 3b is the initial exploratory study of pathway preferences and Study 3c is the substantive confirmatory study.

3.2 Methods

3.2.1 Participants and Sampling Technique

The sampling methods and the sample characteristics were the same as in the previous chapter. However, 706 participants were surveyed for the exploratory study (3b) while 1127 (Nigeria-based) and 105 (UK-based) were surveyed for the confirmatory study that was based on the same sample across the research.

3.2.2 Instrument

An original psychometric scale was developed for the studies from items pulled from the content analysis of qualitative data gathered from the target (Igbo) population. The process of the scale's development followed the pattern described in Chapter two for the Social Distance scale (Study 2b, section 2.2.2). The initial qualitative data was collected in text form; respondents were asked to list the possible steps they could take to help someone close to them recover from mental illness. Some of responses that were elicited include; 1. 'I will take the person to the nearest hospital'. 2. 'Mental illness can come as a result of abomination committed against the land so I will first seek the advice of elders'. Content analysis was used to create codeable units from the data. Three treatment pathways were pre-specified – traditional, spiritual and conventional psychiatry (Adewuya & Makanjuola, 2009). The units were defined based on the treatment options (pathways) they communicated. Each unit was coded to the appropriate treatment pathway. Seven units were realised under both the traditional and the spiritual treatment pathways while 4 units were realised under the conventional psychiatric pathway making the up

the 18 potential items for quantitative instrument. Each of these was articulated in a simple declarative statement framed with a four-point Likert response scale: strongly agree, agree, disagree and strongly disagree. These were subsequently deployed in gathering the quantitative data. To further refine the scale, following data entry into SPSS, the items were subjected to the Principal Component Analysis (PCA). Prior to performing PCA, the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of many coefficients at .3 and above. The Kaiser-Mayer-Olkin value was .86, exceeding the recommended value of .6 (Kaiser, 1970, 1974) and Bartlett's Test of Sphericity (Bartlett, 1954) was highly significant, ($p < .001$) supporting the factorability of the correlation matrix. The PCA result is provided in the result section.

3.2.3 Data Collection

The details of data collection are as reported in the previous chapter. A typical high response rate of 98.5% was achieved in the exploratory study. The response rate for the confirmatory study is constant (as reported in Chapter One).

3.2.4 Data Analysis

Data analysis was as described in Chapter One section 1.2.4. There were seven demographic variables and three help-seeking pathway constructs (Traditional, Spiritual and Conventional Psychiatry). However, mean comparison of the constructs to determine their significant difference was by one-way repeated measures ANOVA. Standard multiple regression analyses were used to assess the ability of the demographic variables to predict the pathways to mental healthcare.

3.3 Results

3.3.1 Study 3a (Principal Component Analysis)

PCA revealed the presence of 4 components with eigenvalues exceeding 1, explaining 26.7%, 9.6%, 8.5% and 6.4% of the variance. However, an inspection of the scree plot reveals a more

prominent levelling off of the slope after the third component. A three-factor solution was therefore specified for the PCA for further investigation. The resultant 3 factors all had eigenvalues over 1, thus easily satisfying the Kaiser-Guttman criterion ($\lambda > 1.0$), and accounted for 44.8% of the variance. The factor loadings are shown in Table 3.1.

Table 3.1 Factor loadings for the Pathway to Mental Healthcare scale

Item	Factors		
	1	2	3
Item 1 A mentally ill person can get better if sacrifices are offered for his past mistakes	.733		
Item 2 People can get mental illness if they keep disregarding our culture and tradition	.700		
Item 3 If someone under my care becomes mentally ill, I will seek the advice of elders	.641		
Item 4 Mental illness is better handled in the native or traditional way	.612		
Item 5 A mentally ill person can get better if he confesses to all the evils he has done	.587	.442	
Item 6 A mentally ill person can get better if he keeps paying his tithes or making offerings to God	.537		
Item 7 Mental illness can come as a result of abomination committed against the land	.517	.389	
Item 8 If someone is mentally ill, he should be taken to a prayer house		.735	
Item 9 If someone becomes mentally ill, he should be exorcised	.345	.676	
Item 10 Mental illness can be cured through breaking of ancestral curses		.604	
Item 11 If I become troubled in spirit for a long time, I may go and see my priest or pastor		.602	
Item 12 Mental illness is a spiritual problem	.303	.561	
Item 13 Mental illness is an illness like any other illness		-.531	
Item 14 If I become troubled in spirit or depressed for a long time, I may go and see a doctor		-.447	
Item 15 Mentally ill people should be taken to psychiatric hospital			.767
Item 16 If I notice signs of mental illness in someone under my care, I will take the person to the nearest hospital			.691
Item 17 Taking mentally ill people to mental or psychiatric hospital can worsen their case	-.313		.638
Item 18 Mentally ill people can get better if they follow good advice			.412

Following orthogonal (varimax) rotation, items loading strongest onto factor 1 consisted of those measuring Traditional Pathway to mental healthcare e.g. ‘if someone under my care becomes mentally ill, I will seek the advice of elders’. Items loading strongest unto factor 2 consisted of those measuring Spiritual Pathway e.g. ‘if someone becomes mentally ill, he should be exorcised’ while factor 3 consisted of items measuring Conventional Psychiatric Pathway e.g. ‘mentally ill people should be taken to psychiatric hospital’. Cronbach’s alpha and item-total correlations were computed for each of the three factors. The first factor (Traditional Pathway) recorded a good alpha of .79. The second factor (Spiritual Pathway) recorded an alpha of .46;

removal of items 13 and 14 which had an item-total correlation of -.248 and -.162 respectively increased the alpha to .80. The third factor (Orthodox Pathway) recorded an alpha of .55; the removal of item 18 which had an item-total correlation of .220 increased the alpha to .60.

3.3.2 Exploratory Study (3b)

The demographic characteristics of the sample are summarised in Table 3.2.

Table 3.2 Socio-demographic Characteristics of the Exploratory Study Sample

Characteristics	N	%
Gender		
Male	244	34.6
Female	462	65.4
Age		
Young	544	77.6
Old	156	22.3
Marital Status		
Not married	472	68.1
Married	221	31.9
Educational Status		
Low education	193	27.6
High education	507	72.4
Religious Denomination		
Protestant	262	38.9
Catholic	411	61.1
Familiarity with Mental Illness		
Not familiar	216	34.3
Familiar	405	64.4
Occupation		
General public	196	28.3
Students	190	27.4
Teachers	92	13.3
Nurses	215	31.0

There were more female (65.4%), young (77.6%) and unmarried (68.1%) respondents. There were also more respondents with higher education (72.4%) and more Catholics (61.1%). The majority of the respondents (64.4%) were familiar with persons with mental illness.

Table 3.3 Descriptive Statistics for Pathways to Mental Healthcare (Exploratory Study 3b)

Demographic Variables		Pathways to Mental Healthcare																	
		Traditional						Spiritual						Conventional Psychiatry					
		Agree		Disagree		Mean		Agree		Disagree		Mean		Agree		Disagree		Mean	
		N	%	N	%			N	%	N	%			N	%	N	%		
Gender	Female	124	30.0	289	70.0	2.25	.54	240	55.4	193	44.6	2.50	.55	419	93.1	31	6.9	3.0	.44
	Male	88	38.9	138	61.1	2.38	.57	140	62.5	84	37.5	2.59	.57	206	86.6	32	13.4	2.9	.50
Age	Young	150	30.1	349	69.9	2.27	.54	290	57.4	215	42.6	2.52	.57	488	91.9	43	8.1	3.0	.46
	Old	59	43.4	77	56.6	2.38	.61	85	57.8	62	42.2	2.52	.55	133	87.5	19	12.5	2.9	.44
Marital Status	Not Married	133	30.5	303	69.5	2.27	.55	248	57.1	186	42.9	2.51	.56	425	92	37	8.0	3.0	.46
	Married	73	38	119	62	2.34	.57	122	58.1	88	41.9	2.53	.55	189	88.3	25	11.7	2.9	.44
Educational Status	Low Educ.	96	54.2	81	45.8	2.54	.50	137	76.1	43	23.9	2.80	.53	161	85.2	28	14.8	2.80	.47
	High Educ.	114	25.0	342	75.0	2.20	.55	239	50.7	232	49.3	2.42	.53	459	92.9	35	7.1	3.0	.44
Religious Denomination	Protestant	71	29.8	167	70.2	2.22	.55	143	58.8	100	41.2	2.56	.56	223	88.5	29	11.5	2.92	.47
	Catholic	129	34.5	245	65.5	2.32	.57	218	57.2	163	42.8	2.51	.56	372	92.1	32	7.9	2.95	.46
Familiarity with Mental Illness	Not Familiar	56	28.4	141	71.6	2.25	.50	106	51.5	100	48.5	2.51	.52	195	94.7	11	5.3	2.94	.40
	Familiar	140	37.7	231	62.3	2.34	.60	233	62.3	141	37.7	2.54	.59	355	89.2	43	10.8	2.93	.48
Occupation	Teachers	19	25.0	57	75.0	2.29	.46	53	61.6	33	38.4	2.53	.43	83	93.3	6	6.7	2.90	.37
	Students	84	47.5	93	52.5	2.50	.48	126	73.3	46	26.7	2.73	.50	171	91.9	15	8.1	2.88	.45
	Gen. public	68	39.1	106	60.9	2.36	.60	103	56.3	80	43.7	2.53	.57	158	84.0	30	16.0	2.9	.47
	Nurses	36	18.1	163	81.9	2.05	.57	88	43.3	115	56.7	2.31	.58	203	95.3	10	4.7	3.06	.45
Overall Score		212	33.2	427	66.8	2.29	.56	380	57.8	277	42.2	2.52	.56	625	90.8	63	9.2	2.94	.45

The cumulative pattern of pathway endorsements as presented in Table 3.3 showed that a predominant 90.8% (Mean 2.94, SD .45) of respondents endorsed the Conventional Psychiatric Pathway while a little above half (57.8%, Mean 2.52, SD .56) endorsed the Spiritual Pathway and a third (33.2%, Mean 2.29, SD .56) endorsed the Traditional Pathway. A one-way repeated measures ANOVA was used to compare the mean scores. Mauchly's test showed that the assumption of sphericity was violated ($\chi^2(2) = 201.72, p < .001$); therefore degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\epsilon = .78$). The results showed that pathway preferences differed significantly ($F(1.60, 912.90) = 534.06; p < .001$; partial eta sq. = 0.48). Post hoc Bonferroni tests confirmed that more respondents significantly preferred the Orthodox Pathway to the Spiritual ($p < .001$) and Traditional Pathways ($p < .001$). However, more respondents significantly preferred the Spiritual to the Traditional Pathway ($p < .001$).

The demographic variables were used in a standard multiple regression analyses to predict the pathways to mental healthcare (see Table 3.4).

Table 3.4 Standard Multiple Regression of Demographic Variables as Predictors of Help-seeking Pathways (Exploratory Study 3b)

	Traditional pathway			Spiritual pathway			Conventional Psychiatry		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Constant	16.09	1.31		15.58	1.03		9.69	.59	
Gender	-.24	.35	-.03	-.10	.28	-.02	-.06	.16	-.02
Age	.39	.51	.04	-.34	.41	-.05	-.03	.23	-.01
Marital Status	.515	.46	.06	.28	.36	.04	-.36	.21	-.10
Educational Status	-1.72	.41	-.20***	-1.42	.33	-.21***	.47	.19	.13*
Religious Denomination	.50	.31	.06	-.42	.24	-.07	.13	.14	.04
Familiarity	.04	.32	.01	-.02	.25	-.00	-.03	.14	-.01
Students vs. Nurses	2.02	.47	.24***	1.53	.37	.23***	-.15	.21	-.04
Teachers vs. Nurses	1.04	.57	.09	1.35	.45	.15**	-.37	.26	-.08
General Public vs. Nurses	1.05	.49	.16*	.82	.39	.12*	-.46	.22	-.12*

Note * $p < .05$ ** $p < .01$ *** $p < .001$

The linear regression model was statistically significant in the prediction of Traditional Pathway $F(9, 561) = 9.33, p < .001$, and accounted for 13.0% of the variance ($R^2 = .13$). Occupational group made the strongest and statistically unique contribution to the preference for the Traditional Pathway: nurses were significantly less likely to prefer the traditional pathway than the students ($\beta = .24, t(570) = 4.28, p < .001$). Nurses were also significantly less likely to prefer the traditional pathway than the general public ($\beta = .13, t(570) = 2.14, p < .05$). Low education

also made a statistically significant unique contribution to the preference for Traditional Pathway ($\beta = -.20$, $t(570) = -4.13$, $p < .001$). The regression model was also statistically significant in the prediction of the Spiritual Pathway $F(9, 573) = 8.83$, $p < .001$, and accounted for 12.2% of the variance ($R^2 = .122$). Occupational group made the strongest and statistically unique contribution to the preference for the Spiritual Pathway: nurses were significantly less likely to prefer the spiritual pathway than students ($\beta = .23$, $t(582) = 4.13$, $p < .001$). Nurses were also significantly less likely to prefer the spiritual pathway than teachers ($\beta = .15$, $t(582) = 3.03$, $p < .05$) and the general public ($\beta = .12$, $t(582) = 2.13$, $p < .05$). Low Education also made a statistically significant unique contribution to the preference for Spiritual Pathway ($\beta = -.21$, $t(582) = -4.35$, $p < .001$). The model was also statistically significant in the prediction of the Conventional Psychiatric Pathway $F(9, 589) = 3.98$, $p < .001$, and accounted for 5.7% of the variance ($R^2 = .057$). High education made the strongest and statistically significant unique contribution to the preference for the Conventional Psychiatric Pathway ($\beta = .13$, $t(598) = 2.53$, $p < .05$). Occupational group also made a statistically significant unique contribution to the preference for the Conventional Psychiatric Pathway: nurses were significantly more likely to prefer the Conventional Psychiatric Pathway than the general public ($\beta = .12$, $t(598) = 2.10$, $p < .05$).

3.3.3 Confirmatory Study (3c)

For the demographic characteristics of the confirmatory study sample (which is constant for the entire research) see as summarised in Table 1.9 (Chapter One, section 1.3.2).

Table 3.5 Descriptive Statistics for Pathways to Mental Healthcare (Confirmatory Study)

Demographic Variables		Pathways to Mental Healthcare																	
		Traditional						Spiritual						Conventional Psychiatry					
		Agree		Disagree		Mean		Agree		Disagree		Mean		Agree		Disagree		Mean	
		<i>N</i>	%	<i>N</i>	%			<i>N</i>	%	<i>N</i>	%			<i>N</i>	%	<i>N</i>	%		
Gender	Female	378	51.8	352	48.2	2.48	.51	469	63.5	270	36.5	2.70	.66	703	93.5	49	6.5	3.42	.54
	Male	195	60.2	129	39.8	2.57	.48	242	72.9	90	27.1	2.83	.62	309	91.7	28	8.3	3.33	.55
Age	Young	425	56.4	329	43.6	2.52	.51	479	62.9	282	37.1	2.70	.68	727	93.8	48	6.2	3.45	.53
	Old	148	50.0	148	50.8	2.49	.48	231	76.0	73	24.0	2.85	.58	279	90.6	29	9.4	3.25	.57
Marital Status	Not Married	371	56.6	284	43.4	2.52	.51	420	63.1	246	36.9	2.70	.67	642	95.5	30	4.5	3.47	.51
	Married	198	50.3	196	49.7	2.49	.50	286	71.5	114	28.5	2.80	.62	363	88.5	47	11.5	3.26	.59
Educational Status	Low Educ.	131	67.2	64	32.8	2.73	.54	162	83.1	33	16.9	3.04	.61	181	90.0	20	10	3.29	.58
	High Educ.	438	51.2	418	48.8	2.46	.48	546	62.4	329	37.6	2.67	.65	828	93.5	58	6.5	3.42	.54
Religious Denomination	Protestant	229	53.9	196	46.1	2.50	.50	286	67.0	141	33.0	2.76	.68	409	92.7	32	7.3	3.37	.57
	Catholic	322	54.5	269	45.5	2.51	.50	398	65.6	209	34.4	2.72	.63	565	92.6	45	7.4	3.41	.54
Familiarity with Mental Illness	Not Familiar	194	56.9	147	43.1	2.51	.46	408	70.5	104	29.5	2.78	.59	333	93.5	23	6.5	3.37	.53
	Familiar	323	51.3	307	48.7	2.49	.52	408	64.5	225	35.5	2.71	.68	602	93.2	44	6.8	3.42	.55
Occupation	Students	160	75.8	51	24.2	2.81	.51	179	81.4	41	18.6	3.00	.61	210	95.5	10	4.5	3.43	.48
	Teachers	149	58.4	106	41.6	2.55	.48	198	75.9	63	24.1	2.88	.60	241	89.6	28	10.4	3.24	.57
	Nurses	113	36.7	195	63.3	2.27	.45	117	38.4	188	61.6	2.34	.63	303	96.5	11	3.5	3.62	.46
	Gen. Public	134	53.2	118	46.8	2.50	.44	199	77.4	58	22.6	2.83	.57	231	89.5	27	10.5	3.25	.58
Overall Score Nig-based		577	54.4	484	45.6	2.51	.50	716	66.4	362	32.1	2.74	.65	1017	92.8	79	7.2	3.24	.55
UK-based Gen. Public Sample		37	37.8	61	62.2	2.30	.55	52	52.0	48	48.0	2.51	.65	95	93.1	7	6.9	3.39	.52

The cumulative pattern of pathway endorsements as presented in Table 3.5 showed that a predominant 92.8% (Mean 3.24) of the Nigeria-based respondents endorsed the Conventional Psychiatric Pathway while approximately two-thirds (66.4%, Mean 2.74) endorsed the Spiritual Pathway and a little over half (54.4%, Mean 2.51) endorsed the Traditional Pathway. A one-way repeated measures ANOVA was used to compare the mean scores. Mauchly's test showed that the assumption of sphericity was violated ($\chi^2(2) = 363.11$, $p < .001$); therefore degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\epsilon = .77$). The results show that pathway preferences differed significantly, ($F(1.53, 1532.87) = 783.27$; $p < .001$; partial eta sq. = .44). Post hoc Bonferroni tests confirmed that more respondents significantly preferred the Conventional Psychiatric Pathway to the Spiritual ($p < .001$) and Traditional Pathways ($p < .001$). However, more respondents significantly preferred the Spiritual to the Traditional Pathway ($p < .001$).

Table 3.5 also showed the cumulative pattern of pathway endorsements by the UK-based general public sample. A predominant 93.1% (Mean 3.39) of respondents endorsed the Conventional Psychiatric Pathway while approximately half 52.0% (Mean 2.51) endorsed the Spiritual Pathway and a little more than a third 37.8% (Mean 2.30) endorsed the Traditional Pathway. A one-way repeated measures ANOVA was used to compare the mean scores. Mauchly's test showed that the assumption of sphericity was violated ($\chi^2(2) = 53.99$, $p < .001$); therefore degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\epsilon = .69$). The results show that pathway preferences differed significantly, ($F(1.38, 127.12) = 99.11$; $p < .001$; partial eta sq. = .52). Post hoc Bonferroni tests confirmed that more respondents significantly preferred the Conventional Psychiatric Pathway to the Spiritual ($p < .001$) and Traditional Pathways ($p < .001$). However, more respondents significantly preferred the Spiritual to the Traditional Pathway ($p < .001$).

An independent sample t-test showed that the difference in preference for the traditional pathway by the Nigeria ($M = 2.50$, $SD = .44$) and the UK-based ($M = 2.30$, $SD = .55$) general

public samples was statistically significant, $t(348) = 3.21, p = .01$, (two-tailed). The magnitude of the differences in the means (mean difference = .20, 95% *CI*: .09 to .31) was small (eta squared = .03). The difference in preference for the spiritual pathway by the Nigeria-based ($M = 2.83, SD = .57$) and the UK-based ($M = 2.50, SD = .65$) general public samples was also statistically significant, $t(355) = 4.62, p = .001$, (two-tailed). The magnitude of the differences in the means (mean difference = .32, 95% *CI*: .19 to .46) was moderate (eta squared = .08). The difference in preference for the Conventional Psychiatric Pathway by the Nigeria-based ($M = 3.24, SD = .58$) and the UK-based ($M = 3.39, SD = .52$) general public samples was also statistically significant, $t(358) = -2.09, p = .01$, (two-tailed). The magnitude of the differences in the means (mean difference = -.14, 95% *CI*: -.27 to -.00) was small (eta squared = .01).

Table 3.6 Standard Multiple Regression of Demographic Variables as Predictors of Treatment Pathways (Confirmatory Study)

	Traditional pathway			Spiritual pathway			Conventional Psychiatry		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Constant	20.72	1.06		14.77	.85		10.06	.44	
Gender	-.22	.29	-.03	-.25	.23	-.04	.04	.12	.01
Age	-.54	.39	-.06	.11	.32	.02	.09	.17	.03
Marital Status	.10	.37	.01	.03	.29	.00	-.27	.15	-.08
Educational Status	-1.00	.35	-.10**	-1.05	.28	-.13***	.25	.15	.06
Religious Denomination	.00	.24	.00	-.38	.19	-.06*	.17	.10	.05
Familiarity	.03	.25	.00	-.15	.20	-.02	.13	.11	.04
Students vs. Nurses	4.03	.39	.41***	2.97	.31	.37***	-.52	.16	-.13**
Teachers vs. Nurses	2.55	.38	.28***	2.65	.30	.35***	-1.08	.16	-.29***
General Public vs. Nurses	1.86	.42	.20***	2.11	.34	.28***	-.98	.18	-.26***

Note * $p < .05$ ** $p < .01$ *** $p < .001$

The demographic variables were used in a standard multiple regression analyses to predict the pathways to mental healthcare (see Table 3.6). The linear regression model was statistically significant in the prediction of Traditional Pathway $F(9, 961) = 19.74, p < .001$, and accounted for 15.6% of the variance ($R^2 = .156$). Occupational group made the strongest and statistically unique contribution to the preference for the Traditional Pathway: nurses were significantly less likely to prefer the traditional pathway than the students ($\beta = .41, t(970) = 10.37, p < .001$). Nurses were also significantly less likely to prefer the traditional pathway than teachers ($\beta = .28, t(970) = 6.70, p < .001$) and the general public ($\beta = .20, t(970) = 4.45, p < .001$). Low

education also made a statistically significant unique contribution to the preference for Traditional Pathway ($\beta = -.10$, $t(970) = -2.84$, $p < .01$). The regression model was also statistically significant in the prediction of the Spiritual Pathway $F(9, 975) = 22.82$, $p < .001$, and accounted for 17.4% of the variance ($R^2 = .174$). Occupational group made the strongest and statistically unique contribution to the preference for the Spiritual Pathway: nurses were significantly less likely to prefer the spiritual pathway than students ($\beta = .37$, $t(984) = 9.57$, $p < .001$). Nurses were also significantly less likely to prefer the spiritual pathway than teachers ($\beta = .35$, $t(984) = 8.71$, $p < .05$) and the general public ($\beta = .28$, $t(984) = 6.30$, $p < .001$). Low Education ($\beta = -.13$, $t(984) = -3.72$, $p < .001$) and Protestant denomination ($\beta = -.06$, $t(984) = -1.94$, $p < .05$) also made statistically significant unique contribution to the preference for Spiritual Pathway. The model was also statistically significant in the prediction of the Conventional Psychiatric Pathway $F(9, 980) = 12.24$, $p < .001$, and accounted for 10.1% of the variance ($R^2 = .101$). Only occupation made a statistically significant unique contribution to the preference for the Conventional Psychiatric Pathway: nurses were significantly more likely to prefer the Conventional Psychiatric Pathway than teachers ($\beta = -.29$, $t(989) = -6.78$, $p < .001$). Nurses were also significantly more likely to prefer the Conventional Psychiatric Pathway than the general public ($\beta = -.26$, $t(984) = -5.59$, $p < .001$) and students ($\beta = -.13$, $t(984) = -3.19$, $p < .01$).

3.4 Discussion

The need to evolve a more responsive model of mental healthcare from the convoluted 'free market' system observable in traditionalist (collectivist) societies of the developing world motivated this study of the Igbo people of south-eastern Nigeria. Mixed treatment preferences were evident as more than half of the respondents made endorsements across the three (traditional, spiritual, conventional psychiatric) treatment models. Paradoxically however, both the exploratory and confirmatory studies found a significant preference of the conventional psychiatric treatment pathway to both the spiritual and the traditional pathways

and also a significant preference of the spiritual to the traditional pathway. These patterns are demonstrated by both the Nigeria and UK-based respondents. A possible positive interpretation of this finding is to consider it a reflection of paradigm shift from earlier prevalence of superstitious conceptualisations of mental illness to increasing scientific understanding based on improved mental health literacy. This prospect agrees with Chapter One of this research which found significant increasing endorsement of the biological and psychosocial causal explanatory models in this region.

Mental health conceptualizations including causal beliefs held significantly shape help-seeking behaviours and pathway preferences (Muga & Jenkins, 2008; Compton et al., 2006; Carteret, 2011). Improved mental health literacy could also imply greater recognition of the evidence base of orthodox care. As Hugo and colleagues (2003) noted, while there is certainly a case that the concept of “a pill for every ill” should not be fostered, it is increasingly clear that medication plays a crucial role in containing the symptoms of serious disorders such as schizophrenia. Many of the respondents including nurses and family members of patients may have experienced manifest containment of symptoms of patients following medication. Clients in a South-African study who expressed satisfaction with the treatment they received in district hospitals and mental health institutions based their contentment on significant reduction of symptoms they experienced following medication (Mkize & Uys, 2004). The finding here reflects the report of Furnham and Igboaka (2007) in their comparison of young British and Nigerian respondents. While the Nigerian respondents in the study recognised traditional and religious practices as possible treatment options, they favoured orthodox psychiatric interventions and supportive environments as treatment models even more than their British counterparts.

However, there can be discrepancy between attitude (the high endorsement of the conventional psychiatry model) and subsequent behaviour (the actual patronage of a care provider) as behaviours are triggered by a complex interaction of attitudes, values, and situational variables

(Wong, 1997). Such discrepancy is exemplified in the findings from two recent studies of clinical samples from this population which indicate that the majority of respondents initially followed traditional and spiritual pathways prior to arriving at the biomedical psychiatric facility. In the first study by Odinka and colleagues (2014), while 61.1% and 14.7% of the clinical sample initially took the spiritual and traditional pathways respectively, only 9.2% took the biomedical psychiatric pathway. In the second study by Aniebue and Ekwueme (2009), there was leading initial choice of spiritual pathway (34.4%) before the biomedical psychiatric (32%) and the traditional (13.6%) pathways. These corroborate the earlier mentioned reports from around Nigeria and Africa which all indicated that the majority of patients had used the alternative services either alone or prior to presenting at conventional mental health facilities.

A possible explanation for this discrepancy between attitude and subsequent behaviour lies in the sample difference between our study (non-clinical sample) and the aforementioned studies (clinical samples). As symptom severity is a major determinant of help-seeking (Biddle et al. 2004), clinical samples would be more pragmatic in their approach and possibly more desperate too. An Igbo adage aptly captures this situation ‘adighi eji anya oma eje uka Sabbath’ – it is desperation that drives people to healing churches. This is reinforced and may play out, for example, when uninformed families are faced with the mostly unforeseen onset of psychotic conditions such as schizophrenia with the attendant symptoms, some of which can be very bizarre and coming at the prime of life. Such ‘strange’ occurrence would then ‘logically’ attract supernatural attribution fuelled by the deeply religious worldview of the people (Ikwuka et al., 2014). This explains why the majority of respondents in the aforementioned study of clinical samples by Odinka and colleagues most of whom initially presented at spiritual care indicated that their reason for this choice is belief that the illness is due to supernatural factors while the respondents in the study by Aniebue and Ekwueme indicated that their choice was informed by the confidence they had in the spiritual care pathway. However, as Angermeyer and

colleagues (2001) observed, if initial treatment experiences fail, the formal expert system is clearly favoured which explains why the clinical samples eventually turned up at the conventional psychiatric facility. This also reflects the temporality of pathways. However, it is usually late by the time the decision to present at the formal expert system is reached and effected resulting in significantly degenerated symptoms. This situation is reflected in the finding that there is substantial delay in obtaining effective care for first-episode schizophrenia patients (Lincoln & McGorry, 1995; Larsen, McGlashan & Moe, 1996).

Another important situational variable capable of bringing discrepancy between attitude and behaviour in this context is social desirability as observed in the responses of participants in a related Indian study (Kulhara, Avasthi & Sharma, 2000) whereby only 33% of respondents endorsed that magico-religious treatments could improve the patient's condition while in reality the pathway was taken in 58% of the cases. Regardless of perceived efficacy of biomedical psychiatric interventions, 'colonial mentality' is still evident in sub-Saharan - the thinking that foreign (Western) products are better than their local variants. People in the region appear primed to conceive being trendy as synonymous with Western lifestyle hence the Western model is normally conceived of as the ideal. For instance, it is not uncommon in this region to see youths clad in hooded winter jackets in the heat of the tropical African sun all in the bid to appear 'trendy' in the footsteps of 'the white man'. Such mindset is reinforced in the seeming 'imperialisation' of mental health as evident, for example, in the Western creation of official categories of mental illnesses - The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and the ICD which have become worldwide standards. The panels that finalise these diagnostic categories are unrepresentative of the global population. For instance, only 2 of the 47 psychiatrists who contributed to the initial draft of the World Health Organization's diagnostic system (ICD-10: WHO, 1992) were from Africa, and none of the 14 field trial centres were located in sub-Saharan Africa (White, 2013).

The Western bias of conventional psychiatry is equally evident in the finding that over 90 per cent of papers published in a three-year period in six leading psychiatric journals came from Euro-American countries (Patel & Sumathipala, 2001). The bias also imposes a methodological limitation to pathway studies whereby contacts with alternative or non-physician services are usually underreported possibly because of the perception that informal contacts do not warrant equal status on the help-seeking pathway (Lincoln & McGorry, 1995). Aligning with the conventional 'white man's' model would therefore be the more socially acceptable choice to make especially before an undergraduate research assistant who epitomises Western world-view. Respondents may therefore have given an answer they considered pleasing to or affirmative of the world-view of the person surveying them. They may be reluctant to admit to preference for the traditional healer whose appearance and paraphernalia of office appear primitive. And not being under the pressure of symptom severity, (our) non-clinical samples would have the leisure of responding according to which behaviours are socially desirable.

Socially desirable responses could furthermore be fuelled in the Nigerian context by the increasing bad press and credibility problems suffered by spiritual and traditional care providers regarding their alleged shady dealings which are furthermore exaggerated in the virtual world of the hugely popular Nigerian home video industry - Nollywood. For instance, writing in the Guardian UK on December 9th 2007, Tracy McVeigh notes that "Evangelical pastors are helping to create a terrible new campaign of violence against young Nigerians. Innocent children and babies branded as evil are being abused, abandoned and even murdered while the preachers make money out of the fear of their parents and their communities.... For the most part, these so-called servants of God do nothing but peddle fear and recrimination. In a maddened state of terror, parents and whole villages turn on the child. They are burnt, poisoned, slashed, chained to the trees, buried alive or simply beaten and chased off into the bush." Similarly, in the Thisday Newspaper issue of 7th May 2014, the leading columnist

Eniola Bello described the ‘miracle working’ pastors pervasive in the Nigerian Pentecostal genre as ‘merchandising miracles’. Projecting the triumphalism of Christianity, spiritual healers who see themselves as the bridge between the backward and outdated traditional healers and the modern, scientifically based Western medicine take their rivalry with the traditional model to the home video screens where many Evangelical Churches sponsor proselytising movies that associate traditional medicine with diabolism and excessive blood rituals thus making it socially abhorrent. Hence, the traditional pathway is made to appear obsolete and unfashionable which explains why traditional healing are mostly sought nocturnally. Moreover, visits to traditional healers are taken suspiciously because of possible questionable motives; it is believed that people could go to traditional healers to get cures for their ailments, to get prophylactics against future misfortunes, or to seek diabolical means to retaliate against enemies (Mulatu, 1999). In the main however, it must to be recognized that contempt for native systems has a structural link with the historical colonial demonization and subsequent banning of African traditional beliefs and practices.

Yet, that more than half of the respondents endorsed spiritual and traditional care in spite of the foregoing only goes further to underscore how deeply socio-cultural and religious norms, beliefs and values shape the manner in which the people conceptualise and respond to experiences including psychopathology hence the indispensability of spiritual and traditional healthcare in this region. Practitioners and policy makers must therefore not assume homogeneity of approach to mental healthcare in indigenous societies. Indeed, it would be more auspicious to heed the call of the UN Permanent Forum on Indigenous Issues (2000) for a complementary approach to healthcare in these contexts. It must be recognised that no healthcare model is self-sufficient, nor are different models equally capable of rendering help quantitatively or qualitatively. It further needs to be recognised that traditional/religious beliefs and biomedical mental healthcare need not be mutually exclusive as complementary model of care does not equate to syncretism.

As Patel and colleagues (1995) suggested, both biomedical and traditional/spiritual healers could help persons with mental illness by resolving different issues relating to the same illness. Since patients with psychosis present early to traditional and faith healers in the region (Odinka et al., 2014), constructive engagement with these alternative care providers could provide the needed access to patients for decisive early intervention. Dialogue with them needs to proceed with an openness that allows the possibility of cross-referral whereby the biomedical psychiatric model could, for instance, defer to the traditional model especially when conditions are scientifically inexplicable as could happen with culture-bound phenomena about which it has been observed that biomedical psychiatry has no satisfactory response (Roe & Swarbrick, 2007). The merit of cultural therapies is further underscored, for instance, in the observation that participation in religious and cultural rituals is helpful in coping with crisis (Shalhoub-Kevorkian, 2005). Granting the alternative healers some form of recognition in this way could motivate them to be open to system of referral which they lacked and which has been a major source of impasse in advancing mental healthcare in the convoluted system in this region. On this note too, alternative healthcare providers are deserving of inclusion in mental healthcare initiatives.

Moreover, to facilitate therapy, causal theories and prescriptions for cure need to be meaningful to the patient in terms of the realities they understand. If patients do not believe in the theories of the cause and/or cure advanced for their conditions, it may affect treatment adherence and follow-up which potentially compromises therapy. The significance of an inductive bottom-up approach to care is furthermore reinforced in the observation that how a people in a culture conceptualise mental illness – how they categorise and prioritise the symptoms, attempt to heal them, and set expectations for their course and outcome influences the diseases themselves (Watters, 2010). As questions have been raised regarding the extent that biomedical psychiatric outcomes are culturally sensitive and inclusive (Vaillant, 2012), the traditional approach could also provide a model for cultural appropriateness of services.

For instance, its grounding in a strong social network counters the impersonal setting of psychiatric care where the patient, dislocated from strong social network bonding is expected to bare the inner turmoil of their private life to a virtual stranger of usually higher education and/or social class. Furthermore, following Litwak's (1968) formulation, traditional kinship structures, resting on permanent relationships, can support long-term commitments to care; friendship ties, resting on free choice and affectivity, can support the provision of new information; based on geographical proximity, neighbours can deal with emergencies, while the formal mental health system, resting on trained expertise and concentrated resources, can provide specialized segmented services. Thornicroft (2008) had observed that Blacks especially are more likely to seek help if their families are supportive, and if a family member has had a positive personal experience of mental health care. Hence a healthcare system that isolates the family would inadvertently alienate the patient from their natural therapeutic space.

Meanwhile, having a culturally competent professional would be a good starting point in this need for a bottom-up approach that recognises the importance of local conceptualisations of mental health difficulties. Cultural competency entails an understanding of a people's rules for behaviour, language, religion, history, traditional beliefs and values (Cross, Bazron, Dennis & Isaacs, 1989) which enables professionals to be more empathic and forge therapeutic alliances with clients. Campinha-Bacote (2002) identified five components of cultural competence to include: *awareness*, or sensitivity to values and lifestyles of clients; *knowledge*, or mastery of information about alternative worldviews as well as biological variations among groups; *skill*, or a collection of relevant data regarding health problems; *encounter*, or face-to-face meetings with diverse peoples; and *desire*, or the motivation to ally with patients. Comprehensive reviews of literature reveal that increased cultural competence significantly improves patient satisfaction with treatment and participants undergoing cultural competence programmes showed significant gains in knowledge

about and attitudes toward culturally different groups (Beach et al., 2005; Price et al., 2005).

A culturally competent professional would allay the fears of potential clients that they may be misdiagnosed by the formal health system or their beliefs and values dismissively pathologised. Most importantly, a culturally competent professional would be better placed to recognize and intervene when beliefs are indeed becoming pathological since the recognition of mental disorder depends to a large extent on the understanding of the norms, beliefs and customs within the individual's cultural environment. Ultimately, such a professional would be better primed for work in the complementary model that envisages consultation with, referral to, or joint therapy with trained spiritual and traditional practitioners (Koenig, 2007). The prospect of such a culturally competent professional meeting clients at the crossroads of their help-seeking ventures would dispose clients to come forward. This would include those who, otherwise, would be dissuaded by the estranging atmosphere of conventional psychiatric care or those who would have continued to live in denial of their beliefs and symptoms because of pressure of social desirability and stigma.

Ignoring the beliefs of clients would cause psychiatry to miss an important psychological and social factor that may either be a powerful resource for healing or major cause of pathology (Koenig, 2008). The need for cooperation with indigenous models was further reinforced by the findings of three cross-national studies by the World Health Organization: the International Pilot Study of Schizophrenia (IPSS) (WHO, 1979), the Determinants of Outcome of Severe Mental Disorder (DOSMeD) (Jablensky et al. 1992), and their sequel, the International Study of Schizophrenia (ISoS) (Harrison, Hopper, Craig et al. 2001). These all suggest that schizophrenia has a better prognosis in non-industrialized societies which is traceable to values in these societies including family support and enabling styles of interaction.

Indigenous psychiatrists recognize the need to educate and integrate spiritual and traditional healers into the mainstream biomedical mental health services for maximised service delivery (Yusuf, 2010). In most of the traditional societies, it has also been shown that indigenous healing methods are already considered complementary to the medical management of mental illness (Saravanan et al., 2008). Complementary approach to care has worked effectively in a southern African (Lesotho) context (Obioha & Molale, 2011) and equally in Europe (Sevilla-Dedieu et al., 2010). In the imaginative programme in Hungary, pastors train alongside mental health professionals because of the observed link between people's mental health, religion and spirituality (Tomcsanyi, 2000). Pakistan equally exemplifies an innovative and comprehensive strategy specifically designed to take advantage of local opportunities to meet some of the challenges faced in developing countries. The strategy includes collaborating with traditional healers who have received some training, leading to increased identification and professional referral of individuals with mental disorders (Rahman, Mubbashar, Gater & Goldberg, 1998). These examples help to debunk perceptions that biomedical mental health care and religious or traditional beliefs have nothing in common.

The study found that higher education significantly contributed to the preference for the conventional psychiatric pathway while low education significantly contributed to the preference for the traditional and spiritual pathways. These findings have been replicated elsewhere (Adewuya & Makanjuola, 2009; Kovess-Masfety et al., 2007; Mulatu, 1999). It is to be expected that more education would facilitate the paradigm shift from the pre-scientific to the more scientific conceptualizations of mental illness. Given that education in the colonies follows the Western (colonial) tradition, it is to be expected that the more it is acquired, the more it would dispose recipients to greater preference for the Western biomedical model of healthcare. Furthermore, those with better education who are presumably better exposed to information may have better awareness of available professional mental health services. On the other hand, lack of education may imply a poor

understanding of mental illness and the reinforcement of belief in supernatural causations hence greater likelihood of preferring the supernatural and traditional pathways. However, it is also likely that more education which suggests higher social status could provoke greater tendency for socially desirable responses. On the other hand, less education which suggests less social status could conversely imply less tendency for socially desirable responses hence the likelihood of more reliable responses from this group.

The study also found significant contribution of occupational variables to pathway choices. Expectedly, nurses contributed significantly more to the preference for the conventional psychiatric pathway and significantly less to the preference for the traditional and spiritual pathways compared with those in the non-nursing occupational groups - students, teachers and the general public. The nursing profession exposes nurses to the biomedical psychiatric model and its prospects more than the non-nursing groups. The nurses' significant preference for this model could therefore be an endorsement of its effectiveness. This is reinforced by the fact that the general nursing programme in this region includes the compulsory psychiatric experience in one of the state psychiatric hospitals. This finding underscores the significance of mental health education in disposing people towards formal psychiatric healthcare. However, as with the more educated (with presumable higher social status), the nurses could be more inclined to making socially desirable responses proper to their profession compared to the other non-medical professional groups. Yet, it is not entirely auspicious that nurses demonstrate less regard for the traditional and spiritual care models. Cultural competence in care to which nurses are called and which has been consistently found to improve patient satisfaction with treatment would entail a degree of familiarity and empathy with these alternative models which have proved to be very relevant to clinical samples in this region.

Protestants predicted greater preference for the spiritual pathway. This relates to previous finding that Protestants in this region demonstrate greater supernatural causal attribution for mental illness which is linked to their being more indigenized than the Rome-mediated Catholic denomination (Ikwuka et al., 2014). These findings would help in targeting of awareness campaigns for conventional psychiatric healthcare. They would also equip mental health professionals with the knowledge of demographic groups and their favoured pathways which can make for greater therapeutic alliances.

The finding that the Nigeria-based sample preferred the traditional and spiritual pathways significantly more than the UK-based sample while the UK-based sample preferred the conventional psychiatric pathway more significantly than the Nigeria based sample is expected. A possible methodological explanation for this could be found in there being more respondents with high education in the UK-based sample compared to the Nigeria-based sample given that higher education significantly contributed to the preference for the conventional psychiatric pathway. However, it is also possible that acculturation (social conditioning) to the host culture has influenced the choosing pattern of the immigrant population. Moreover, with the conventional psychiatric model as the official system of care in the host culture, the UK-based sample is relatively more 'restricted' to choosing this model as they do not have the privilege of choosing between alternatives which the 'free market' system accords the Nigeria-based sample. Yet, that more than a third of the sample and more than half indicated preference for the traditional and the spiritual pathways respectively is considerable enough to have implication for their help-seeking behaviour in the host culture. As earlier indicated, recourse to these alternative models is associated with delayed presentation at orthodox psychiatric facilities. Hence, there is the possibility of delayed presentation at psychiatric facilities following mental illness by members of this population in the UK. Secondly, even if one is bound to present at the conventional psychiatric facility in the host culture, there is the possibility of discounting the effectiveness of the treatment which

may affect treatment compliance. The finding calls for measures to improve mental health education of immigrants. It equally calls for cultural sensitivity in provision of care for clients from this group.

3.4.1 Conclusion

This study found significantly mixed preference for biomedical psychiatry, spiritual and traditional pathways to mental healthcare. This reflects holistic view of health and healing and potentially suggests the temporality of pathway with the possibility of switching of pathways in the course of a disorder. However, there was the cheering finding of significant high preference for formal psychiatry compared to the spiritual and traditional models. This could be possibly linked to improved mental health literacy and development in science and technology. Yet, there is a possibility of discrepancy between attitude (in terms of high preference for the biomedical model) and behaviour (the actual choice of pathway when faced with mental health crises) as suggested in the findings of studies with clinical samples that demonstrated initial greater preference for the alternative pathways. Such variables as sudden onset of psychosis with symptoms that could appear strange to the uninformed could lead to supernatural conceptualisation of the condition hence recourse to the spiritual/traditional pathway. Secondly, there is also the possibility of responses being biased by social desirability effects. A complementary model of care is proposed as having the potential to be more responsive in the peculiarity of the terrain. While the pragmatics of the process must be determined, a culturally competent professional could be a starting point for a process that recognises the importance of local conceptualisations for a more responsive approach in mental health service delivery.

Meanwhile, as the experience of mental health service is a significant determinant of service use (Gulliver, Griffiths & Christensen, 2010; Kelly, Jorm & Wright, 2007), the extent to which the finding here of greater preference for the formal psychiatric pathway would translate to practice in this population would, to some degree, be determined by the

pragmatics of accessing care. This and more will be highlighted in the next chapter which discusses barriers to mental healthcare in the region.

Chapter Four (Study 4)

Barriers to Mental Healthcare

4.1 Introduction

The majority of people meeting the criteria for mental disorders globally underutilize mental health services in spite of the availability of effective treatment for most mental disorders (Le Meyer et al., 2009; Burgess et al., 2009; Jagdeo et al., 2009). Studies have consistently found that even after clear-cut signs of psychotic disorders are developed, on average it is over a year before assessment and treatment are received (Compton, Kaslow & Walker, 2004; Johannessen et al., 2001; Black et al., 2001). Delays of more than 10 years are common if intervention is not made in the first year of the onset of mental illness (WHO/ICPE, 2000; Wang, et al., 2004). Studies observe disparity in access and service utilization between ethnic and mainline populations with the former underperforming (Mitchell, Malak & Small, 1998; Tobin, 2000). Such pattern is observed of many ethnic groups in a range of settings e.g. the Punjabi in the UK (Bhui et al., 2001), Hispanic and Asian groups in the USA (Sue, 1977) and Vietnamese in Australia (Phan, 2000). Whereas 16.6% of White adults received mental health services in the US in 2011, only 7.6% of Blacks, 7.3% of Hispanics, and 6.5% of Asians received any treatment (Corrigan, 2014). Generally, 35 – 50% of people with a serious mental disorder in developed countries failed to receive treatment in the last 12 months, a figure which is doubled to 76.3 - 85.4% in developing countries (Demyttenaere et al., 2004). Studies also indicate that ethnic minority clients tend to terminate counseling at the rate of more than 50% after only one contact with a therapist which is in marked contrast to the less than 30% termination rate among White clients (Sue, Sue, Sue & Sue, 1997). A number of studies indicate that the utilization rates for mental health services by Africans are disproportionately low compared to the burden of potentially treatable problems (Gaines, 1998; Kamya, 2001; Wong, 1997). The proportion of those with mental health needs

receiving formal mental healthcare in Nigeria over 12 months was as low as 1.6% (Wang et al. 2007). Indeed, the under-utilisation of mental health facilities has been implicated as being behind the previously held view that Africans as a group have a lesser need for mental health services than do Caucasians (Vaughn & Holloway, 2009).

4.1.2 Help-seeking Determinants

Help-seeking for mental illness is a dynamic process shaped by the following factors which shall be subsequently discussed in detail; socio-cultural factors such as beliefs, values, mental health conceptualisations, idioms of distress and social networks (Fuller et al. 2000; Jack-Ide and Uys, 2013); psychosocial factors such as stigma and clinical factors such as symptom severity (Biddle et al. 2004; Platz et al., 2006). It is also determined by level of mental health literacy (Henderson, Evans-Lacko & Thornicroft, 2013) and socio-economic and systemic factors including: accessibility of services, quality of care and policy directives (Afolayan & Okpemuza 2011; Zartaloudi & Madianos 2010; Gulliver, Griffiths & Christensen, 2010).

4.1.2.1 The Socio-cultural Context

Culture is a social context in which people share social norms, beliefs, values, language and institutions (Guerra & Jagers, 1998). It provides a cognitive map of unwritten rules for living (Leininger & McFarland, 2002) and a framework for interpreting and giving meaning to personal experiences (Lindsfarne, 1998). Thus, the culture of a people is a model for human behaviour as people generally act in ways that correspond to cultural influences and expectations. Culturally constructed beliefs function as a prism in perceiving mental health issues and shaping pathways for help-seeking (Leong & Lau, 2001; Tabora & Flaskerud, 1997). People can feel ‘trapped’ within the values of tradition that affect perceptions of mental health issues and willingness to engage with services (Gilbert, Gilbert & Sanghera, 2004; Sen, 2001). Arab women, for instance, could feel obliged to operate within a set of norms of family and community honour that can override personal concerns (Kassam, 1997). Living in a society that is both collectivist and paternalistic, these

women see no acknowledged legitimization for deviating from the traditional path (Abu-Baker, 2005). In these cultures, women can perceive themselves as ‘carriers’ of family honour, requiring them to modulate their actions so as not to bring shame (dishonour) upon the family (Gilbert, Gilbert & Sanghera, 2004). Exploring psychological distress and self-harm, Chew-Graham and colleagues (2002) found that ‘Izzat’ (a set of norms of family and community honour in Asia) could be used to reinforce a woman’s subordinate role in family life and to coerce women into remaining silent about their problems. Asian students were found to be far more focused on external shame (what others think) and reflected shame (shame they can bring to others like family), than non-Asian students yet they do not suffer any less from internal shame (Gilbert et al., 2007). Studies of Asian and African immigrants in mainline Western cultures also show that the more closely people adhered to their ethnic cultural values, the less likely they were to seek professional psychological help for mental health concerns (Hamid, Simmonds, & Bowles, 2009; Essandoh, 1995). The attitudes and perceptions of the community towards psychiatric disorders equally play a major role in the social reintegration of people with mental illness (cf. Chapter two).

4.1.2.2 The Conceptualisation of Disease

The cultural environment plays a key role in the conceptualisation of disease. It influences the construction of what is normal and abnormal behaviour and the interpretation of an event as stressful (Nwokocha, 2010, Okafor, 2009; Thomas, 2008). It influences the manner in which people define and act upon symptoms and life crises (Angermeyer, Matschinger & Riedel-Heller, 2001). Thus, mental illness assumes cultural meaning which shapes the way people perceive, suffer and cope with mental illness. Demonstrating contextual variation in help-seeking behaviours, a pioneering study that used identical data collection processes and instruments in Egypt, Kuwait, Palestine, and among Israeli Arabs found that respondents within the various countries, based on nationality, gender and level of education, vary in

terms of recognition of personal need, beliefs about mental health problems and the use of traditional healing methods versus modern approaches to psychiatric therapy (Al-Krenawi et al., 2009). Asian respondents who ascribed to western models of illness had more positive disposition towards seeking Western conventional psychiatric model of care while those that endorsed supernatural beliefs had more negative attitudes towards conventional psychiatric care (Fung & Wong, 2007). The appeal of the non-medical care model is mostly informed by their compliance with the judgments of the patients pertaining to the meaning and nature of health and illness, their world views, and their religious beliefs (Chadda, Agarwal, Chandra, & Raheja, 2001). Cultural beliefs about the causes of mental illness influenced attitudes associated with seeking professional help for mental illness (Sheik & Furnham, 2000; Aghukwa, 2012). Cultural misconceptions about mental illness could also lead to negative stereotypes of established systems of care and help-seeking (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999). It has been observed that factors that lead patients from ethnic backgrounds to feel alienated from mainline orthodox healthcare clinics and providers include different understandings of mental illness (Martin, 2009; Vera et al., 1998), and ignorance of culturally different symptom expression (Hunter & Schmidt, 2010; Tófoli, Andrade, & Fortes, 2011).

Lack of bilingual and bicultural professionals create cultural and linguistic barriers that prevent immigrants from obtaining proper mental health care (Spector, 1996). Impasse might result in the therapeutic process if cultural conceptualisation of disease is not taken into account. Angel and Thoits (1987) report how the failure to consider how Mexican culture shapes the self reports of physiological symptoms of Mexican Americans resulted in serious errors in the findings of epidemiologic studies which underrated the illness for individuals at greater risk of poor health. In *Crazy Like Us*, Watters (2010) cites cross-cultural examples demonstrating how the global 'imposition' of Western conceptualisations of mental illness has potentially altered how distress is manifested or introduced barriers to recovery.

Following the tsunami that struck Sri Lanka in 2004, Watters recalls how Gaithri Fernando, a young Sri Lankan Clinical Psychologist resident in the US who witnessed the tsunami observed that unlike the PTSD symptomatology which informed the intervention introduced by the emergency services from the West, Sri Lankans were much more likely to report physical symptoms (somatisation). They did not report pathological reactions to trauma in line with the internal states (anxiety, fear, numbing etc) of the PTSD symptom checklist but the negative consequences of the disaster were evaluated in terms of the damage they did to social relationships. Regier and colleagues (1988) note that the general public in the West are more likely to recognise mood rather than somatic symptoms (of depression) which is different in Arabic, Asian and African cultures where somatisation is a common expression of mental illness and description of mood changes are rare. For similar pathologies, the West would report feeling worthless, losing interest in usual activities, being unable to start or finish anything and contemplating suicide (Idemudia, 2004).

Russell and colleagues (2008) found that a greater number of immigrant students presenting with more severe mental health symptoms felt the need to seek help from medical health professionals rather than counselling services. Compared with American students who tend to experience stress as anxiety and/or depression (Aubrey, 1991), foreign students struggle with the discrimination between emotional distress and somatic illnesses and may attribute their problems to organic processes (Flaskerud, 1986; Russell, Thomson & Rosenthal, 2008). Thus, somatisation of mental distress could lead to delay in psychiatric help-seeking as problems may be conceived as organic rather than psychological. On the other hand, it is observed that some clinicians from mainstream cultures fail to recognise or appreciate the seriousness of somatised symptoms expressed in some of the immigrant cultures (Nwokocha, 2005) and as a result not all the symptoms are being addressed.

There are also cultural variations in the indicators of good or poor mental health. For instance, Earle (1998) reported that compared to a Caucasian sample, American Indians considered

attributes such as having visions or living according to the dictates of spirits as good mental health indicators. Suan and Taylor (1990) also found that Japanese-American college students rated characteristics such as untrustworthiness, exhibiting poor interpersonal relations and a negative personality as stronger indicators of poor individual mental health than Caucasian-American college students. Labels of conditions such as 'schizophrenia' and 'mental illness' are also understood differently across cultures. For example, a survey in Germany found that 79.6% of the public believe that people with schizophrenia suffer from split or multiple personalities (Gaebel, Baumann, Witt & Zaeske, 2002) compared to only 47.2% in a Canadian public sample (Stuart & Arboleda-Florez, 2001a). A more recent cross-national study found that 31.6% of a German sample linked schizophrenia with split personality compared with only 2.0% of a Russian sample (Schomerus et al., 2007). Angermeyer and colleagues (2004) found that labelling of a schizophrenia vignette was associated with perceived dangerousness in a sample of the German public but not in Russian or Mongolian samples. The Nigerian general public conceive mental illness mainly in terms of severe psychotic disorders (madness) (Igbinomwanhia, James, Omoaregba, 2013, Atilola & Olayiwola, 2011) and associates mental illness with vagrancy (Ewurdjakpor, 2010b). Characteristic modes of expressing distress (idioms of distress) are also mostly based on cultural and contextual peculiarities (Nichter, 1981). Cultural determination of distress is to an extent that Angel and Thoits (1987) suggested arguably that the clinical facts of the disease are only loosely related to the subjective experience of the illness.

The foregoing indicates that different conceptions of mental health significantly exist and may be misunderstood by the therapist particularly those from different backgrounds with the client. It underscores the need to analyze and understand particular manifestations of distress in context and indicates that determining the conceptualization of mental health could help in understanding the differences in attitudes about

mental illness, symptom presentation and help-seeking behaviours thereby helping to unravel the reasons for underutilization of mental health services. This would furthermore equip therapists to make more accurate diagnoses for effective culturally appropriate interventions.

4.1.2.3 Cultural (in)appropriateness of care

The cultural appropriateness of conventional psychiatric treatment has been called into question (cf. discussion on Chapter three). Conventional mental health services may be perceived as having strong historic and epistemological anchors to Western Europe and North America. An ethnocentric view of psychopathology can limit our understanding of disorders in general and the pathways through which non-Westerners can approach treatment (Gaines, 1998; Idemudia, 2004). Moreover, the heritage of relations between the dominant White and ethnic minorities means that there are profound reasons why some people will be suspicious of what is seen to be a White-dominated service. For instance, for most post-colonial peoples, there may be politically embedded ambivalence towards modern mental health services: regardless of perceived efficacy, mental health services are identified as part of the colonial process and have a limited cultural sensitivity towards minority groups (Al-Krenawi & Graham, 2011). Antipathy towards conventional psychiatric care and the popularization of the traditional model could therefore be expressive of nationalistic mindset and pro-indigenization policy which seems to enjoy state support in Nigeria with government encouragement of frequent media advertisement of traditional medicine healers who openly challenge the utility of Western medicine, thus making them (traditional medicine) very popular especially among the poor (Uzochukwu & Onwujekwe, 2004). Mental health services represent Western culture insofar as they may be perceived as ignoring native values which may hinder their acceptance.

The process of psychiatric diagnosis (the international classification systems) has been

criticised for assuming that diagnostic categories have the same meaning when carried over to a new cultural context (Kleinman, 1977, 1987; see also Chapter three). Prior to ICD-10 which acknowledged that there are exceptions to the presumed universality of psychiatric diagnoses, culture-specific disorders such as brain fog syndrome (a concept initially used almost exclusively in West Africa to depict a condition often associated with male students and generally presenting as vague somatic symptoms, depression and difficulty concentrating) and *koro* (a form of genital retraction anxiety which presents in parts of Asia) tended to be subsumed into such established diagnostic categories as delusional disorder (Crozier, 2011). Minas and Cohen (2007) note that a major impediment to the development of effective, appropriate, affordable and equitable mental healthcare delivery system is the lack of evidence-based information on what kinds of mental health systems that are appropriate and effective in varying political, social and economic contexts. Bolman (1968) had earlier observed that one of the major obstacles in the development of mental health services in the developing non-Western world is the difficulty in making culturally and linguistically specific adaptations of Western scientific approaches. The dissonance is immediately evident in the observation that public beliefs regarding the causes of mental disorders and the effectiveness of various treatments differed significantly from those of mental health professionals and that despite their knowledge base, the cultural values of health professionals still affected their attitudes towards their care of persons with mental illness (Afolayan & Okpemuza, 2010; Angermeyer & Matschinger, 1996; Jorm et al., 1997; Magliano et al., 2004). Socio-cultural differences between the provider and consumer engender systematic biases and misunderstandings that hamper communication between providers and consumers (Betancourt & Maina, 2007). Conflicts between traditional and Western cultural values lead to high dropout rates and underutilization of community mental health resources (Hsu, 2003). Cultural mistrust or misunderstanding between therapists and clients is often used to explain the existence and perpetuation of racial and ethnic disparities in mental health help-seeking and utilization (Nickerson, Helms & Terrell, 1994; Suite, La Bril, Primm & Harrison-Ross,

2007).

Lack of cultural competence and appropriate intervention strategies on the part of treatment providers constitute the most formidable barriers to mental health service use by non-Western cultures (Takeuchi, Bui & Kim, 1993). They are considered to make services less user-friendly for patients from Non-English-Speaking Backgrounds (NESB) (Mitchell et al., 1998; Tobin, 2000) and could result in the pattern whereby ethnic minority groups may have higher rates of mental illnesses, lower rates of general referral and treatment but higher rates of compulsory treatment and forensic service contact (Keating & Robertson, 2004; National Institute for Mental Health in England, 2003). The American Psychological Association has indeed acknowledged that the disparity does not stem from a greater prevalence rate or severity of illness in ethnic minority groups but from a lack of culturally competent care and their receiving less or poor quality care (APA, 2012).

Cultural appropriateness of service is the most significant predictor of attitudes towards seeking professional help for mental illness as found with five ethnic minority groups (Fung & Wong, 2007). White women felt more comfortable with predominantly White health care providers than their Black and Hispanic counterparts (Doornbos et al., 2013) which is consistent with previous findings where depressed African-American women had a deep mistrust of the healthcare system as a 'White system' (Nicolaidis et al, 2010). It has been observed that Hispanics, Native Americans, Blacks and Asian-Americans have a tendency for early termination of psychotherapeutic treatment and also average fewer sessions than Whites (Sue et al., 1997). This may not be unconnected with the possibility that the therapists fail to provide culturally responsive forms of treatment. Communication problems due to language barriers have equally been implicated in non-attendance at outpatient clinics (Stern et al. 1990). As earlier noted (cf. Chapter three), the more populations become diverse, the more the need for culturally competent and appropriate health care services. It is observed that the relatively more positive attitude of the American population towards mental health services is

traceable to the ubiquity of the facilities (Al-Darmaki 2003). As culture shapes the patient's mental health and service use as well as that of the care providers and the service system with respect to diagnosis and treatment, cultural differences must be accounted for to ensure that all receive mental healthcare tailored to their needs.

Carrillo and colleagues (1999) note that for mental health service delivery to be effective and efficient, key socio-cultural issues that are relevant to the provision of cultural responsive services must be considered e.g. salience of family and social support, importance of religion or spirituality, stress of migration, barriers of language or literacy and impact of socio-economic factors. Significant dislocation from one's culture even in the process of therapy can be maladaptive (Chen, Benet-Martinez, & Bond, 2008). Thus, the therapist must, of necessity, be an ecologist - realising that his patient has desires, beliefs, habit and patterns of associations all of which influence his health (Awojobi, 2011). To make for culturally competent therapy, the British Psychological Association's Division of Clinical Psychology recommends adherence to guidelines stipulating that all clinical psychologists must contribute to directly providing psychological therapies which take into account cultural differences, the impact of racism on psychological health and the specific needs of Black and Minority Ethnic people (British Psychological Association, 1998). Furthermore, following a landmark case in ethnic minority mental health whereby David Bennett, a 38-year-old African-Caribbean man died on 30 October 1998 in a medium secure psychiatric unit after being restrained by staff, many issues that needed resolving in the UK National Health Service (NHS) surrounding cultural and racial equality in mental healthcare were highlighted. The government responded in 2005 with a plan for Delivering Race Equality in Mental Healthcare (DRE) which aimed at more appropriate and responsive services, community engagement and better information. Among other things, DRE aimed that by 2010, mental health services in the UK will be characterised by; Less fear of mental health services among Black and Minority Ethnic (BME) communities and service users; A reduction in the rate of admission of people from

BME communities to psychiatric inpatient units; A reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units; A reduction in the use of seclusion in BME groups; More BME service users reaching self-reported states of recovery; A reduction in the ethnic disparities found in prison populations; A more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective; A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy and in the planning and provision of services; A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

Similarly, the US Surgeon General Report (DHHS, 2001) noted that minorities typically delay seeking treatment and encouraged the development of ethnic-specific-programmes that match patients to therapists. Furthermore, considering the influx of immigrants to the United States from 1990 to 2000, the US social service and mental health systems equally generated new services, appropriate sensitivities and interventions for the nation's newest immigrants (Foster, 2001). Faced with the more challenging aspect of other cultural models such as spirit-based belief, the Western therapist will require openness to the guidance of non-Western colleagues and patients in order to overcome stereotypical responses (Dixon, 2008; Nyagua & Harris, 2007). Lin advocates for close adherence to the tenet of cultural relativity, together with efforts in obtaining relevant information regarding the meaning and consequences of the symptoms in the patient's cultural context but also notes that excessive preoccupation with cultural influences in psychiatric symptom presentation may conversely lead to the underestimation of psychopathology. He therefore called for adequate attention to the universal aspect of psychopathology in counterbalancing such a tendency (as cited in Thomas, 2008).

4.1.2.4 Culture of self-reliance

Culturally gendered roles may have implication for help-seeking. For instance, men are generally socialised to believe that power, dominance, competition and control are essential in proving one's masculinity (Robertson & Fitzgerald, 1992). It has also been noted that males are significantly less likely from early age to report problem or seek help due to deep-seated need to appear in control and not to show vulnerability which is based on this traditional sex role stereotyping and ideology of self reliance (Elliot-Schmidt & Strong, 1997; Benenson & Koulmazarian, 2008). In contrast to the traditional masculine gender role prescriptions, people who seek psychological services have often been stereotyped as crazy, weak, or out of control (Corrigan, 2004). And in contrast to women, men may also associate formal help-seeking with a diminishment of their abilities to be strong providers and family leaders (Komiti, Judd & Jackson, 2006; El-Islam 2000). Furthermore, men's traditionally advantaged social status, greater control and decision-making power, and higher income than women, may make it difficult to accept a diagnosis of a potentially disabling condition such as mental disorder or seek help for it (Judd, Komiti & Jackson, 2008). These could lead to preference for self coping, seeking help as a last resort or reliance on informal over formal services. Self-diagnosis of illness is very common in the masculinist Igbo system as noted by Uzochukwu and Onwujekwe (2004), though this could also be adaptive response to the poor and inadequate mental health system. Furthermore, the strong traditional masculinity in this system entails that 'men should be men' - they should subdue their emotions. For instance, it is effeminate to shed tears. Hence, emotions which could be symptomatic and assist diagnosis could be stifled. One consequence of masculinist disposition is the finding that men's mental conditions upon treatment entry are typically more serious (Smith, Tran & Thompson, 2008) possibly owing to belated presentation at mental health facilities.

Research also suggests that adolescents and young adults demonstrate the most tendencies for self-help in dealing with mental health difficulties (Gulliver, Griffiths & Christensen, 2010; Rickwood, Deane & Wilson, 2007). Such stoic culture of avoiding overt expressions of feelings and display of emotion and the traditional sex role stereotyping and ideology of self reliance are also believed to be more pronounced in rural compared to urban communities (Komiti, Judd & Jackson, 2006; Fuller et al., 2000). Seeing seeking help from professionals as a sign of personal weakness, over 80% respondents in the study by Komiti and colleagues agreed that a person should work out their own problems while consulting professionals as a last resort and this was endorsed by more males than females. Good and Wood (1995) suggest that men's attitudes could be altered by reinterpreting psychological help-seeking as a behaviour requiring personal courage and strength which are consistent with traditional masculinity ideology.

4.1.2.5 The Social Network

The social network as significant determinant of help-seeking pathways has been discussed in Chapter three (see section 3.1.2.3.2.1). However, while the social network can provide care and report symptoms, and could be important sources of advice and information for health-related issues, the dynamics of the social network could also inhibit prompt seeking of mental healthcare. For instance, help from the social network (family, extended family, friends and community members) in the communitarian Igbo society can be unsolicited given that the goodwill of every community member volunteering service is presumed and every suggestion at the time of crisis whether potentially helpful, harmful or even contradictory is open to consideration and often favourably. At times, rivalry could arise between the different arms of the network regarding whose opinion should hold sway and this could add to the stress of the situation while also hampering decisive intervention. The quality of the social network is also a factor; a social network with less mental health literacy could keep recycling ignorance at the detriment of the patient. It is noted that social networks delay in their

recognizing first signs of mental illness hence may not inform prompt intervention and that families and friends most often suggest seeking care particularly when socially disturbing symptoms become prominent (Mkize & Uys, 2004; Gater et al., 2005). Furthermore, as Mkize and Uys observed, with the structure of the family in the communitarian African system whereby there is usually the adult (male) head, there could be delay in decisive intervention in the event of sudden crisis since the family head who would normally take the final decision is usually away from home toiling to cater for the family.

While limited social networks predicted restricted utilisation of mental health resources in a study (Bonin, Fournier, & Blais, 2007), research also hints on the irony of the inhibitive influence of tightly meshed social networks that could lead to delay in contacting health facilities (Rogler & Cortes, 1993; Lin, Inui, Kleinman & Womack, 1982). When networks are open, and the individuals are not too involved with each other, they are more exposed to information about the environment, including where to go for professional treatment. Secondly, people are pressured toward the acceptance of normative beliefs that could run contrary to formal help-seeking in close-knit networks. The impact of the normative expectations could be felt in the finding that networks afraid of stigmatization delay contact with psychiatric services (Angermeyer, Matschinger & Riedel-Heller, 2001). Yet, stigma and discrimination are particularly significant in collectivist societies where communities are smaller, social networks are closely enmeshed and privacy is lacking (Barney, Griffiths, Jorm & Christensen, 2006). Social conflicts arising from the closely knit and communal lifestyles of most African societies have also been associated with the emanation of distress (Asuni, Schoenberg, & Swift, 1994). Parr and Philo (2003) observe that social proximity can be a 'double-edged sword' in the sense that while the experience of social stigma may be more pronounced in small communities, the sense of community may also be a protective factor due to the stronger sense of community and higher social capital in rural communities. Collectivist cultures with strong community support system and

interlocking community and familial network could also feel able to meet their needs from within hence reluctant to seek external help (Tata & Leong, 1994; Gilbert, et al., 2007).

4.1.2.6 Stigma of Mental Illness

Stigma as a factor that impedes treatment and recovery has been discussed in Chapter two (see sections 2.1.4.4 and 2.1.4.5).

4.1.2.7 Mental Health Literacy

Mental health literacy is defined as knowledge and beliefs about mental disorders which aid their recognition, management or prevention (Jorm, 2000). Literature indicates that mental health literacy is positively associated with disposition to seek mental healthcare while lack of knowledge, information, and negative stereotypes of mental illness in the community serve as critical barriers to service utilization (Rüsch et al., 2011; Gulliver, Griffiths & Christensen, 2010; Larson & Corrigan, 2008). Lack of mental health literacy could also act as an impediment to early recognition of a disorder (Hugo et al., 2003). Members of the public generally demonstrate lacking in mental health literacy (Angermeyer & Dietrich, 2006; Magliano et al., 2004). Epidemiological research suggests that as many as half of people with diagnoses such as schizophrenia and bipolar disorder are unaware of their condition (Kessler et al., 2001). Lack of knowledge regarding the availability of effective treatment and where and how to access it also leads to underutilisation of orthodox mental healthcare (Gulbinat et al., 2004; Thornicroft, 2008; Hugo et al., 2003; Thomas, 2008). It was revealing to observe that even medical students demonstrate poor awareness of existing services (Chew-Graham, Rogers & Yassin, 2003). Results from a study that compared international students' awareness and uses of counselling service with their levels of academic stress found that those who were aware of the availability of counselling services reported significantly lower levels of academic stress than those not aware of the availability of those services (Nina, 2009). Belief about psychiatric treatment itself could also constitute a barrier towards seeking the treatment. Some people believe that psychiatric hospitals are for lunatics i.e.

people who are violent, rejected by society, and subsequently locked away (Budman et al., 1992). A community study of attitudes to mental illness in Nigeria showed that more than half of the respondents thought that people with mental illness could not receive treatment from normal health facilities owing to the communities' attribution of dangerousness to people with mental illness (Gureje et al., 2005).

4.1.2.8 Accessibility of Care

Shortage of resources in the help system, inadequate coverage and lack of diversity in mental health workforce could constitute barriers to accessing healthcare (García-Moreno, 2002; Lecrubier, 2005; Edelman & Mandle, 2002). Inadequacy of resources could be informed by structural discrimination - institutional practices and policies that work to the disadvantage of minority groups even in the absence of individual prejudice or discrimination (Link & Phelan, 2001; see also Chapter two section 2.1.4.2). Persistent structural stigma such as insurance barriers and inadequate systems of community support stalls effective efforts to prevent or treat mental illness and leads to negative socio-economic consequences such as the loss of productive workforce (Keusch et al. 2006; Link and Phelan 2006; Stuart 2005). Income level and medical insurance status can significantly predict access, particularly to specialist care (Jagdeo et al., 2009; McAlpine & Mechanic, 2000).

Reviews note lack of accessibility to healthcare facilities especially in rural populations (Fox, Blank, Rovnyak & Barnett, 2001; Gulliver, Griffiths, & Christensen, 2010). Rural people reported not knowing who to seek help from (Wrigley, Jackson, Judd & Komiti, 2005). Accessibility of care was also noted as the most significant predictor of attitudes towards seeking professional help for mental illness among ethnic minority groups (Fung & Wong, 2007). Many studies have indicated that income have an effect on seeking treatment, either independently (Cohen & Hesselbart, 1993; Haines et al. 2002) or as an interaction with symptom severity (Cunningham & Freiman, 1996).

In the less industrialised developing world, conventional mental health facilities are under-equipped and relatively inaccessible, requiring high transport costs with other financial implications. This deter individuals especially those with lower incomes from such services while availability and relative affordability add to the appeal of alternative care pathways (Campbell-Hall et al., 2010; Roberts, 2001; Tang et al., 2007). Indeed, for many in these contexts, traditional healers may be the only affordable and accessible form of healthcare. A study on the treatment of psychiatric disorders in India noted that paucity of conventional facilities for psychiatry leads about 80% of the population to depend on indigenous treatments consisting of Ayurvedic and Unani systems of medicine, religious treatments consisting of prayers, fasting, and so on, and also various witchcrafts and magical rituals (Lahariya, Singhai, Gupta, & Mishra, 2010).

Approximately 70% of mental health services in Nigeria are provided by religious and spiritual healers (Adewuya & Makanjuola, 2009). A study that investigated the barriers to the utilisation of primary health care in Plateau State, north-central region of Nigeria found high costs of drugs (29%), service charges (19%), easy access to traditional healers (39%) and difficulty in getting transport to a health facility (30%) as leading barriers (Katung, 2001). Another study that investigated the burden of schizophrenia on rural and urban families in south-southern Nigeria showed that users experience financial burden in accessing mental health care, keeping follow-up appointments and paying for treatment which results in many being unable to sustain treatment and consequent relapse (Jack-Ide & Uys, 2013). A related study of caregivers' burdens and psychotic patients' perception of social support in Nigeria indicates that service users lacking any form of social welfare support had higher burdens, experienced more family dysfunction and poor illness outcomes (Ohaeri, 2001). Bureaucratic bottlenecks in accessing care also discourage help-seeking. A study that investigated the factors militating against keeping appointment for initial screening at a community mental health centre found a positive relationship between the length of

time that patients have to wait for the first appointment and the rate of failure to keep appointment ('no-show' rate) (Peeters & Bayer, 1999). The most prevalent reasons for 'no-show' were being on the waiting list, lack of motivation and resolution of the mental health problem.

4.1.2.9 Experience of the Mental Health System

The experience of mental health service is a significant determinant of future or continued service use (Gulliver, Griffiths & Christensen, 2010; Kelly, Jorm & Wright, 2007). Ogborn (1995) recounts the many aspects of the mental health treatment that give patients serious concern; regarding medication, they worry about the effectiveness, the side effects, and the risk of drug addiction. They feel concerned about the effectiveness and the frequency of the counselling or consultation sessions, the time necessary to complete the treatment, and that they have to talk about private matters and sometimes painful experiences to others. Patients would therefore expect that specialists are professional and empathetic: highly trained, educated, oriented to the problem, and interested in the personality of their clients and clients' health status. However, these may not always be confirmed in their experience. Negative experiences with mental health services could lead to mistrust of the system and the professionals and these are noted to inform reluctance to seek professional help (Howerton et al., 2007).

Psychiatric practice in general was found to generate exclusion and stigmatization of persons with mental illness (Hugo, 2001). Indeed, sociological literature arguably suggests that stigma is thrust upon persons with mental illness by the psychiatric health system which was seen as being concerned with containment, control, medication or therapy while clients suffered stigma as a result of their often compulsory engagement with it (Crawford & Brown, 2002). Sartorius (2002) observed that psychiatrists have on occasions requested longer holidays and a higher salary than other doctors because they had to work with 'mentally ill patients who are dangerous'. They have

also recommended separate legislation for people with mental illness ‘to protect themselves’ which can further set people with mental illness apart. Such arbitrary behaviours as unwillingness to offer services, overestimation of dangerousness, excessive physical restrictions and over-sedation have been attributed to psychiatric personnel (Livaditis, 1994).

Read and Baker (1996) report that the most ‘intolerant’ group of employers were within health and social care with the worst cases of overt displays of negative attitudes reportedly coming from the nursing and social work professions. Some reports indicate that professionals demonstrate more negative attitudes than the general public. For instance, data from the Viewpoint survey (Henderson, Corker, Lewis-Holmes et al., 2012) suggested that between 2008 and 2009, after the Time to Change social marketing campaign began in January 2009 in the UK, the overall level of discrimination dropped, accounted for by reduced discrimination from a number of sources, including friends, family, neighbours, employers, and education professionals. But there was no reduction in reports of discrimination from either mental or physical healthcare professionals. This corroborates the suggestion that medical staff hold negative attitudes toward people with mental illness which was not amenable to educational and clinical experience (Fabrega, 1995; Shao et al., 1997).

Health professionals were also less optimistic about treatment outcomes for mental illness than the general public (Hugo, 2001). Mental health workers also hold pessimistic attitudes regarding the integration of persons with mental illness into society which may result in providing services that hinder rather than facilitate community integration (Moldovan, 2007). For example, in order to make for the acceptance of persons with mental illness by the community, a group of them were trained to conceal their mental illness and avoid situations which may result in rejection. Review of the outcomes of these interventions showed that instead of facilitating community adjustment, these strategies produced more self-stigma and discouragement (Link, Mirotznik, & Cullen, 1991).

The overwhelming majority of treatment for mental health difficulties is performed by GPs since over 90% of clients are managed in primary care which is preferred by clients and their families because they allow easy access to services, facilitate early diagnosis of problems, and prompt interventions in a person-centred, non-stigmatizing environment (Jenkins et al. 1992; Tylee 1999). Yet, evidence suggests that not all practitioners wish to provide mental healthcare at their surgeries partly because of a lack of knowledge (King, Judd & Grigg, 2001) but also because of 'low therapeutic commitment' to these client group (Crawford & Brown, 2002). A community psychiatric nurse in the study by Crawford and Brown reports that '... there's still sort of a lot of stigma about mental health in GP surgeries ... they don't make the referrals at the appropriate time so we (mental health staffs) tend to get them at crisis point, which can be disastrous.... You can really struggle to get through to the GPs as well.'

Some staffs are unable to develop an essential rapport with mental health patients and this can negatively affect outcome for the patient (Hawton, Daniels & James, 1995; Friedman et al. 2005). Psychiatrists rated mental health patients as 'difficult' 'annoying' and 'un-compliant' (Rao et al., 2009). Packer and colleagues (1994) found that medical residents believed they could not form a therapeutic alliance with chronic mentally ill patients and would not be able to work with them in an individualized manner. Fifty percent of the nurses that participated in a study by Reed and Fitzgerald (2005) expressed a clear dislike of caring for people with mental health problems. Moreover, 27.6% of the doctors and 30.7% of the nurses in a study by Arvaniti and colleagues (2009) claimed that their job did not include services for persons with mental illness. Similar findings were reported by Björkman and colleagues (2008). A study of Kenyan sample suggests that even if they were capable of handling psychiatric problems, general health workers preferred such patients to be managed by specialist mental health institutions to having them managed in general wards (Muga & Jenkins, 2008).

Health and social care professionals' attitudes have direct effect on the quality of care they provide (Griffiths & Pearson, 1988). Health workers may hold on to the mental illness stereotypes to treat the clients contemptibly. For instance, people with mental illness experience physical maltreatment in the hands of healthcare professionals and health workers especially in general hospitals and tend to favour isolation and custodial care of psychiatric patients (Aghukwa, 2009a; Ewhrudjakpor, 2009). Such negative approach results in greater use of physical and chemical restraints on patients (Duxbury, 2002) which undermine human rights (Hundert-mark, 2002) and are objectionable to patients and relatives (Olofsson & Jacobsson 2001, Bonner et al. 2002). Observing a chronic psychiatric ward Donati (2000) notes 'It seemed to me that, in response to the experience of failure and impotence in nursing chronic patients, there arises a defensive urge to extinguish any sign of spontaneity, involvement, emotionality and expectations, and to keep everything lifeless and predictable so as to avert new hopes, new disappointments and intensified frustration, p. 41.' Research suggests that stigma among primary care providers may, in part, contribute to lower quality of care in this population (Thornicroft, 2013).

Forty-four percent of people in London who had experienced mental distress reported having experienced discrimination from their GPs while 35% reported experiencing discrimination from other health professionals (Rao et al., 2009). Service users have also indicated that some nursing staff in acute mental health settings do not display 'liking' towards them in terms of either friendly characteristics or behaviour (The Mental Health Foundation of New Zealand, 2003; Hugo, 2001). Studies report that patients with mental illness feel that they are treated contemptibly and have to wait longer than other patients. They feel often ignored, ridiculed or face the suspicion that their physical complaints may only be figments of their imagination. They experience a lack of interest in their person and the history of their mental health problem.

They suppose that health professionals are ignorant of the side effects of medication, and that psychiatric diagnoses are mostly given with a negative prognosis (Schulze & Angermeyer, 2003; Liggins & Hatcher, 2005).

Patients also express fear of breach of confidentiality which could discourage them from seeking help from professionals (Corrigan, 2004). Some Asian women express fears that any sensitive information about their mental states and difficulties they might share with others, including their GP could be revealed to others (Gilbert, Gilbert & Sanghera, 2004). The insensitivity of professionals sometimes violate the implicit norms of good practice. A community health worker reports ‘... [A] woman ... was having regular visits from a Community Psychiatric Nurse who was female and that wasn’t a problem because it was like a friend going round. Then one day, a man actually turned up with a depot injection in his hand, so that everybody was looking out, and they could see the injection, so it was quite clear that there was something wrong, with ... suitcase, syringe in one hand, you know big nice [healthcare trust] badge, no sort of attempt to cover it up. And after that injection, she said well forget it, I’m not having any more injections, you know’ (Crawford & Brown, 2002).

Sartorius (2002) had observed that the careless use of diagnostic labels is a major contribution of medical professionals to the stigma of psychiatric disorders and the World Health Organization has identified this as a target for its campaign against stigma. Diagnostic terms can be useful in summarising information about a patient's illness and facilitate communication among professionals but they can be harmful when used carelessly by professionals or when left at the disposal of non-professionals who are not familiar with the original definition of the term. As gatekeepers of information and services, the opinion of mental health professionals or their manner of presentation of mental illness and people with mental illness may greatly affect users’ response to professional intervention. The mental health workers’ perception of client’s place in

society also matters a great deal as it is likely to influence client's motivation, compliance, and investment in the therapeutic relationship (Moldovan, 2007). Generally, the reputation of caregivers in terms of their character also shapes the disposition of the client. For instance, in a culture like the Igbo that is moralistic about abuse of substances, it wouldn't help to learn that the prevalence of depression and alcohol-related problems is higher among doctors than in the general population (Chew-Graham, Rogers, & Yassin, 2003).

Negative experience of care can lead to treatment fearfulness - the subjective state of apprehension that arises from aversive expectations about the seeking and consumption of mental health services which is a foremost barrier to help-seeking (Kushner & Sher, 1991; Zartaloudi & Madianos, 2010). Treatment fearfulness includes fear of embarrassment and change, fear of different stereotypes related to treatment, fear related to previous negative experience with mental health services, and fear related to the treatment type. Negative experiences with psychiatric services may inhibit help-seeking when symptoms of a mental disorder first appear (Monteiro et al. 2006).

The demanding nature of mental health services often generates anxiety amongst staff as they work under pressure which could lead to a form of 'misdirected aggression'. Health professionals also report poor knowledge and skill, lack of support, and the need for ongoing assistance and training to provide effective care (King et al. 2001; Muirhead & Tilley 1995). General nurses studied by Reed and Fitzgerald (2005) disliked and avoided caring for persons with mental illness because they were unsure of their responsibilities. They however displayed positive attitudes when given support. Adequate support would bolster the confidence of health care providers which would likely animate the system and motivate the users too. Bailey (1998) reports that poor institutional support results in counter-productive coping tactics like tea room humour as stress release. Venting feelings this way could further perpetuate stereotypical negative responses. As persistence in

the engagement process is the crucial element of the therapeutic process (Gournay, 1996), negative attitude of professionals would be a major barrier to accessing mental healthcare and is therefore deserving of utmost attention by all the stakeholders. As Ogborn (1995) rightly observed, the therapeutic relationship between the patient and the mental health specialist is a crucial interface for the evolution and the outcome of the process of help-seeking. Interpersonal confidence is a necessary element in the therapist/patient relationship for the patient to freely relay painful and personal private information about their life and health, disclosing personal emotions and thoughts, and accepting guidance through life changes that are difficult.

4.1.3 Theoretical Framework and Rationale for study

A number of theoretical models have been adopted to explain health-seeking behaviours (see the review by MacKian, 2003). Among the most widely investigated are the Health Belief Model (Hochbaum, 1958) and The Theory of Planned Behaviour (Ajzen, 1991). The explanatory power of the Health Belief Model (HBM) is based on the individual's perceptions of susceptibility (beliefs regarding the prospect of getting the disease or being harmed by the condition), severity (appraisal of the disease consequences), benefits (a consideration that the benefits of a prescribed action outweigh its barriers) and barriers (e.g. the embarrassment that may go with seeking help or material limitations). Other predictive variables of this model include the presence of an internal or external stimulus (cue-to-action), health motivation (a general predisposition towards health) and self-efficacy. The Theory of Planned Behaviour (TPB) implies rational processes in deciding whether or not to perform a given behaviour. It proposes that behaviour is informed by the strength of the subject's intention (the cognitive representation of one's readiness to carry out a given behaviour) and the degree of actual control the individual has over carrying out the behaviour (the extent to which a subject possesses the requisite skills and resources necessary for the performance of a given behaviour). Strength of intention is determined by attitude (conceptualized as the

degree of an individual's overall favourable or unfavourable evaluation of the behaviour being appraised), the subjective norm of the subject (social pressures and the motivation to comply with these expectations) and perceived behavioural control (subjects' perceptions of their capacity to carry out the behaviour).

A meta-analysis of the Theory of Planned Behaviour (Armitage & Conner, 2001) supported the effectiveness of the theory which accounted for 39% and 27% of the variance in intention and behaviour respectively. The utility of TPB in understanding a variety of health behaviours has also been noted including; condom use (Albarracin, Johnson, Fishbein & Muellerleile, 2001), physical exercise (Hagger et al., 2007), cancer symptoms detection (Hunter, Grunfeld & Ramirez, 2003) and smoking cessation (Higgins & Conner, 2003). As MacKian crucially observed however, the central flaw of these models that evolved in the West is the over-reliance on the individual and the centrality of cognitive processes. This loses the sense that individuals are rooted in social contexts that affect in a far more complex manner the way they process and act on information. This becomes even more overriding in collectivist cultures and may explain why ethnicity considered non-central to these models has proved to be an important determinant of help-seeking behaviour (Edge & MacKian 2010; Shefer et al., 2013; Cheng, Kwan, & Sevig, 2013; Conner et al., 2010). Indeed, the complex interactions between culture and other contexts that so often characterise the lives of those at risk of psychological disorders have been identified at the centre rather than the periphery of human development (Cauce et al., 2002).

Whereas Ajzen expected universal patterns of influence across the key TPB constructs, sample-specific variations on the relative contributions of the constructs can be observed (Deane, Skogstad & Williams, 1999; Walker, Courneya & Deng, 2006). For instance, the degree to which the views of significant others would count in the ultimate decision to seek help is expected to vary between individualistic and collectivist

cultures. Predictably, based on Western samples, the subjective norm (social forces) is generally considered a weaker predictor of intention compared to the more person-centred attitude construct (see the meta-analysis by Armitage & Conner, 2001). It accounted for only 3% of the variance in the intention to seek help compared to the 23% of attitude (Bayer & Peay, 1997). Considering it inadequate and rarely predicting intention, some researchers have removed it from analysis (Sparks, Shepherd, Wieringa, & Zimmermanns, 1995). On the contrary, significant others including family and friends were major determinants of intention to seek help in samples from collectivist cultures. In a Northern Nigerian sample, initial contact with care providers was initiated by relatives and friends in over 4 in 5 of the cases (Aghukwa, 2012). Similarly, among a south-eastern Nigerian sample, initial contact with services was initiated by significant others in nearly 91% of cases (Aniebue & Ekwueme, 2009).

Focus on the individual and symptom rather than on the experience of the individual may illustrate the Western bias toward scientific objectivism (Cauce et al., 2002). Hence, such theories are limited in applicability to inform decisive intervention plans in cross-cultural settings. Furthermore, considered from such person-centred perspective, the concept of help-seeking appears somewhat over-utilised for describing how individuals engage with services but under-theorised for understanding how populations engage with health systems (Mackian, 2003). MacPhail and Campbell (2001) underscored the need to develop a more critical approach to the conceptualisation of health seeking behaviour which takes into account the neglected societal, normative and cultural contexts in which individual-level phenomena such as knowledge, attitudes and behaviour are negotiated or constructed especially in the developing world. Adams (2003) notes that reflexive thinking is always bounded, if not exhausted, by the existing culture and society which historically structures our sense of self and the world beyond. Emphasis need to be led on the way in which groups of

individuals in given social contexts relate to create and reinforce distinct ways of behaving and the emergent health implications. Exploring the underlying socio-cultural factors that underpin decision-making processes with regard to help-seeking therefore becomes an imperative for improving care.

Accessibility of care is equally expected to vary between developing and industrialised societies where the effect of income is considerably less or nonexistent (Zimmerman, 2005). In the light of the limited resources available to support mental health services in the developing world, White (2013) have questioned whether it makes sense to export systems of service delivery that have been developed in high-income countries to Low and Middle Income Countries. Cauce and colleagues (2002) make the important submission that help-seeking is not simply a matter of attitude or personal choices, neither is it merely a reflection of cultural differences, but arise out of a dynamic interaction between individual and family choice, cultural values and beliefs regarding mental health and help-seeking, and contextual and systemic factors such as availability of services within the community and social networks that can provide referrals for them. As earlier noted (cf. Chapter Three), delays in seeking help for mental health problems lead to poorer outcomes. Identifying potential barriers to mental healthcare would therefore inform decisive interventions. Disturbingly, the health seeking behaviour of the poor is a neglected theme in literature (Mackian, 2003) and mental health is generally under-researched in sub-Saharan Africa (Gureje et al., 2005). This undermines the prospects of plugging the striking gaps in treatment in this region and has led to as much as 70% of mental health services in Nigeria being delivered through alternative pathways (Adewuya & Makanjuola, 2009).

The aims of this segment of the research therefore include;

1. To determine to what degree ideological (cultural and mental health literacy) vs. instrumental (systemic and financial) impediments are perceived to constrain mental healthcare among the Igbo people (Nigeria vs. UK based).

2. To determine the demographic predictors of ideological and instrumental barriers to mental healthcare.
3. To compare barriers to mental healthcare across demographic groups.
4. To consider the determinant factors for ideological and instrumental barriers.
5. To propose possible means of addressing barriers to mental healthcare in the region.
6. To develop materials for a new measure of barriers to accessing mental healthcare.

Determining the relative weight, significance and determinants of ideological vs. instrumental barriers to mental healthcare would make for prioritised policy interventions. There are three parts to the study; Study 4a developed the quantitative instrument used in the rest of the study, Study 4b is the initial exploratory study and Study 4c is the substantive confirmatory study.

4.2 Methods

4.2.1 Participants and Sampling Technique

The sampling methods, the number of participants and their characteristics were the same as in the previous chapter for both the exploratory ($n = 706$) and confirmatory ($n = 1127$ Nigeria-based, and $n = 105$ UK-based) studies. While the same exploratory study sample was used for studies (Chapters) 3 and 4, the sample for the confirmatory study was constant across the research.

4.2.2 Instrument

As was the case in Chapters two (study 2d) and three, a self-report instrument was developed from items pulled from the content analysis of qualitative data that was gathered from the socio-cultural context of the study (the target Igbo population). The qualitative data was collected in text form; respondents were asked to list the possible difficulties people could face when seeking mental healthcare for their loved ones. Some of the typical responses that were elicited include: 1. “Noticing it (mental illness) on time may be difficult since madness starts like a joke”. 2. “God forbid that a relative should become mentally ill, madness is never completely cured”. 3. “Getting to a good hospital will be quite a distance”. Content analysis

was used to create codeable units from the data and units were defined once based on one constraint communicated irrespective of their frequency of occurrence in the data. Twenty units were realised in all making up the 20 potential items for quantitative instrument. Each of these was articulated in a simple declarative statement framed with a four-point Likert response scale: strongly agree, agree, disagree and strongly disagree. These were subsequently deployed in gathering the quantitative data. To further refine the scale, following data entry into SPSS version 20, the 20 items were subjected to the Principal Component Analysis (PCA) (Stevens, 1996). Prior to performing PCA, the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of many coefficients at .3 and above. The Kaiser-Mayer-Olkin value was .77, exceeding the recommended value of .6 (Kaiser, 1970, 1974) and Bartlett's Test of Sphericity (Bartlett, 1954) was highly significant, ($p < .001$) supporting the factorability of the correlation matrix. PCA result is provided in the result section.

4.2.3 Data Collection

The details of data collection are as reported in the previous chapter. A typical high response rate of 98.5% was achieved in the exploratory study. The response rate for the confirmatory study (based on the same participants and sampling technique across the chapters) is as reported in Chapter one.

4.2.4 Data Analysis

There were the seven regular demographic variables and two help-seeking barrier constructs (ideological vs. instrumental). Further details of the data analysis are exactly as reported in Chapter three section 3.2.4.

4.3 Results

4.3.1 Study 4a (Principal Component Analysis)

PCA revealed the presence of 6 components with eigenvalues exceeding 1, explaining 16.9%, 8.4%, 6.5%, 6.2%, 5.63% and 5.50% of the variance. An inspection of the screeplot revealed

a clear break after the second component. Using Catell's (1966) scree test, we decided to retain two components for further investigation. The resultant two factors all had eigenvalues over 1, thus easily satisfying the Kaiser-Guttman criterion ($\lambda > 1.0$), and accounted for 25.4% of the variance. The factor loadings are shown in Table 4.1.

Table 4.1 Factor loadings for the Barrier to Mental Healthcare scale

Item	Factors	
	1	2
Item 1 If a person gets mentally ill in the village, gossip will spread about that person	.672	
Item 2 Before discussing the mental health problem of someone close to me with anybody, it must be someone I can trust with a secret	.591	
Item 3 Mental illness makes the sufferer unproductive	.551	
Item 4 Problems like mental illness are better handled privately because of the shame it could bring	.484	
Item 5 It is safer not to get involved with issues like mental illness	.450	
Item 6 It will cost more to treat mental illness than to treat other illnesses	.435	.379
Item 7 Mental illness exists in a continuum	.366	
Item 8 It is difficult to know where to go for mental healthcare because of the different possible causes	.356	
Item 9 We can only know that someone is mentally ill when the person starts misbehaving	.319	
Item 10 If someone under my care becomes mentally ill, I will take the person to the nearest place of treatment irrespective of type.		
Item 11 If someone under my care becomes mentally ill, the nearest place to get good treatment is quite a distance		.540
Item 12 I will consider the cost before deciding on where to take someone to be treated for mental illness		.527
Item 13 Mental illness cannot be totally cured hence there is no point wasting resources		.527
Item 14 If someone under my care becomes mentally ill right now, I am not quite sure of where to find the best treatment		.510
Item 15 Taking mentally ill people to mental or psychiatric hospital is a way of telling the public that the person is mad.		.507
Item 16 Considering the cost of transport, it will be better to look for cure of mental illness locally		.497
Item 17 Places that can offer good treatment for mental illness will normally be too costly	.416	.471
Item 18 Mental illness is usually noticed belatedly for any effective intervention		.459
Item 19 There can usually be long delays in places that can offer good treatment for mental illness		.383
Item 20 If someone under my care becomes mentally ill, I will need to search to get the best treatment for him		.339

Following orthogonal (varimax) rotation, item 10 was removed from the scale as it failed to load onto any of the factors ($< .3$). Items loading strongest onto factor 1 consisted of those

measuring cultural and mental health literacy constraints (Ideological Barriers) e.g. ‘we can only know that someone is mentally ill when the person starts misbehaving’. Factor 2 consisted of items measuring systemic and financial constraints (Instrumental Barriers) e.g. ‘I will consider the cost before deciding on where to take someone to be treated for mental illnesses.’ The scale constructs demonstrated internal consistency with moderate Cronbach alpha coefficient of .62 and .66 respectively. Each of the items had a four-point Likert response scale: strongly agree, agree, disagree and strongly disagree. Participants’ responses were reclassified as agreeing to the proposition if the response were either ‘strongly agree’ or ‘agree’ to the items and disagreeing with the proposition, if the responses were ‘strongly disagree’ or ‘disagree’.

4.3.2 Exploratory Study (4b)

The demographic characteristics of the sample are summarised in Table 4.2.

Table 4.2 Socio-demographic Characteristics of the Exploratory Study Sample

Characteristics	N	%
Gender		
Male	244	34.6
Female	462	65.4
Age		
Young	544	77.6
Old	156	22.3
Marital Status		
Not married	472	68.1
Married	221	31.9
Educational Status		
Low education	193	27.6
High education	507	72.4
Religious Denomination		
Protestant	262	38.9
Catholic	411	61.1
Familiarity with Mental Illness		
Not familiar	216	34.3
Familiar	405	64.4
Occupation		
General public	196	28.3
Students	190	27.4
Teachers	92	13.3
Nurses	215	31.0

There were more female (65.4%), young (77.6%) and unmarried (68.1%) respondents. There were also more respondents with higher education (72.4%) and more Catholics (61.1%). The majority of the respondents (64.4%) were familiar with persons with mental illness.

Table 4.3 Descriptive Statistics for Ideological vs. Instrumental Barriers to Help-seeking (Exploratory Study 4b).

Demographic Variables		Barrier Constructs											
		Ideological						Instrumental					
		Agree		Disagree		Mean SD		Agree		Disagree		Mean SD	
		<i>N</i>	%	<i>N</i>	%			<i>N</i>	%	<i>N</i>	%		
Gender	Female	359	84.5	66	15.5	2.95	.44	221	55.9	174	44.1	2.48	.43
	Male	195	85.5	33	14.5	2.90	.38	121	57.9	88	42.1	2.51	.40
Age	Young	433	86.7	66	13.3	2.96	.42	267	57.0	201	43.0	2.49	.41
	Old	117	78.0	33	22.0	2.84	.42	72	54.1	61	45.9	2.50	.45
Marital Status	Not Married	373	86.3	59	13.7	2.96	.42	230	56.7	176	43.3	2.49	.40
	Married	170	81.3	39	18.7	2.87	.40	104	55.6	83	44.4	2.48	.44
Educational Status	Low Educ.	162	89.0	20	11.0	2.97	.38	115	68.0	54	32.0	2.61	.38
	High Educ.	389	83.5	77	16.5	2.91	.43	223	51.7	208	48.3	2.43	.42
Religious Denomination	Protestant	206	84.4	38	15.6	2.94	.45	126	54.5	105	45.5	2.47	.45
	Catholic	327	85.2	57	14.8	2.92	.40	200	57.8	146	42.2	2.50	.40
Familiarity	Not Familiar	175	86.2	28	13.8	2.93	.42	106	56.1	83	43.9	2.47	.37
	Familiar	319	84.8	57	15.2	2.93	.42	204	58.3	145	41.7	2.51	.44
Occupation	Gen. Public	150	83.3	30	16.7	2.88	.40	93	57.4	69	42.6	2.51	.43
	Students	159	92.4	13	7.6	3.05	.40	112	67.1	55	32.9	2.59	.39
	Teachers	71	82.6	15	17.4	2.91	.42	40	51.3	38	48.7	2.44	.44
	Nurses	166	81.8	37	18.2	2.88	.43	92	49.2	95	50.8	2.40	.41
Overall Score		554	84.8	99	15.2	2.95	0.41	342	56.6	262	43.4	2.48	0.42

The cumulative barrier scores as presented in Table 4.3 showed that over 4 in 5 respondents (84.8%) risk not seeking help for mental illness owing to ideological barriers while a little more than half (56.6%) could be inhibited by instrumental barriers. A one-way repeated measures ANOVA was used to compare these two barrier types and a main effect of barrier type was found, $F(1, 572) = 573.19$; $p < .001$; partial eta sq. = .501). Post hoc Bonferroni tests confirmed that ideological barriers were perceived more than instrumental barriers ($p < .001$).

Table 4.4 Standard Multiple Regression of Demographic Variables as Predictors of Barriers (Exploratory study 4b)

	Ideological Barriers			Instrumental Barriers		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Constant	27.21	1.35		2.59	.16	
Gender	-.71	.36	-.09*	-.04	.04	-.04
Age	-.79	.53	-.09	.01	.06	.01
Marital Status	-.23	.48	-.03	-.00	.06	-.00
Educational Status	.16	.43	.02	-.12	.05	-.13*
Religious Denomination	.01	.32	.00	.03	.04	.04
Familiarity	.12	.33	.02	.02	.04	.02
Students vs. Nurses	1.90	.49	.22***	.13	.06	.14*
Teachers vs. Nurses	1.00	.59	.09	.05	.07	.04
General Public vs. Nurses	.86	.51	.10	.08	.06	.08

Note * $p < .05$ ** $p < .01$ *** $p < .001$

The demographic variables were used in a standard multiple regression analyses to predict the barriers to mental healthcare (see Table 4.4). The linear regression model was statistically significant in the prediction of Ideological Barriers $F(9, 570) = 3.13$, $p < .01$, and accounted for 4.7% of the variance ($R^2 = .05$). Occupational group was a significant predictor: students were significantly more likely to be inhibited by ideological barriers from seeking mental healthcare than the nurses ($\beta = .22$, $t(579) = 3.89$, $p < .001$), but neither teachers nor the general public significantly differed from the nurses in the extent they could be inhibited by ideological barriers. Gender was also a significant predictor: Females were significantly more likely to be inhibited by ideological barriers from seeking mental healthcare than the males ($\beta = .09$, $t(579) = -.196$, $p < .05$). The regression model was also statistically significant in the prediction of Instrumental Barriers $F(9, 529) = 2.85$, $p < .01$, and accounted for 4.6% of the variance ($R^2 = .05$). Educational status was a significant predictor: Respondents with low educational status were significantly more likely to be inhibited by instrumental barriers from

seeking mental healthcare than those with higher educational status ($\beta = -.13$, $t(538) = -2.44$, $p < .05$). Occupational group was also a significant predictor: students were also significantly more likely to be inhibited by instrumental barriers from seeking mental healthcare than the nurses ($\beta = .14$, $t(538) = 2.30$, $p < .05$).

4.3.3 Confirmatory Study (4c)

For the demographic characteristics of the confirmatory study sample (which is same across the research) see as summarised in Table 1.9 (Chapter One, section 1.3.2).

Table 4.5 Descriptive Statistics for Ideological vs. Instrumental Barriers to Help-seeking (Confirmatory study 4c)

Demographic Variables		Barrier Constructs											
		Ideological						Instrumental					
		Agree		Disagree		Mean	SD	Agree		Disagree		Mean	SD
		N	%	N	%			N	%	N	%		
Gender	Female	598	82.0	131	18.0	2.87	.47	397	56.0	312	44.0	2.50	.47
	Male	283	85.8	47	14.2	2.89	.43	199	61.6	124	38.4	2.58	.46
Age	Young	623	81.8	139	18.2	2.85	.46	440	59.4	301	40.6	2.53	.47
	Old	255	87.3	37	12.7	2.94	.43	152	53.3	133	46.7	2.51	.44
Marital Status	Not Married	539	81.7	121	18.3	2.85	.46	393	61.3	248	38.7	2.55	.45
	Married	336	85.7	56	14.3	2.92	.46	201	51.9	186	48.1	2.48	.47
Educational Status	Low Educ.	177	90.3	19	9.7	2.98	.41	134	70.9	55	29.1	2.67	.46
	High Educ.	704	81.8	157	18.2	2.85	.46	463	55.1	378	44.9	2.49	.46
Religious Denomination	Protestant	357	83.4	71	16.6	2.89	.46	238	57.9	173	42.1	2.51	.46
	Catholic	496	83.1	101	16.9	2.85	.45	340	57.8	248	42.2	2.53	.47
Familiarity	Not Familiar	292	85.1	51	14.9	2.87	.43	193	57.4	143	42.6	2.52	.42
	Familiar	518	81.8	115	18.2	2.88	.47	357	57.9	260	42.1	2.52	.46
Occupation	Nurses	221	71.8	87	28.2	2.72	.47	138	45.4	166	54.6	2.37	.44
	Students	197	91.6	18	8.4	3.0	.39	161	77.0	48	23.0	2.75	.42
	Teachers	218	85.8	36	14.2	2.93	.48	141	56.9	107	43.1	2.54	.48
Nig-based Gen. Public Sample		219	86.2	35	13.8	2.90	.43	141	57.1	106	42.9	2.50	.43
Overall Score Nig-based		888	83.3	178	16.7	2.88	.46	601	57.8	438	42.2	2.52	.46
UK-based Gen. Public Sample		62	63.9	35	36.1	2.62	.45	37	38.9	58	61.1	2.37	.46

The overall barrier scores of the confirmatory study as presented in Table 4.5 showed that over 4 in 5 of Nigeria based respondents (83.3%) risk not seeking help for mental illness owing to ideological barriers while a little more than half (57.8%) could be inhibited by instrumental barriers. A one-way repeated measures ANOVA was used to compare the scores and there was significant effect for barrier, $F(1, 998) = 490.24$; $p < .001$; partial eta sq. = .33. Post hoc Bonferroni tests confirmed that ideological barriers were perceived more than instrumental barriers ($p < .001$). Table 4.5 also showed that close to two-thirds of the UK-based sample (63.9%) risk not seeking help for mental illness due to ideological barriers while a little above a third (38.9%) risk being inhibited by instrumental barriers. A one-way repeated measures ANOVA was also used to compare the scores and there was significant effect for barrier, $F(1, 90) = 36.83$; $p < .001$; partial eta sq. = .29. Ideological barriers were significantly perceived ($M = 2.62$, $SD = 0.44$) more than instrumental barriers ($M = 2.37$, $SD = 0.46$). An independent sample t-test showed that the difference in ideological barrier scores between the Nigeria ($M = 2.88$, $SD = .46$) and the UK-based ($M = 2.62$, $SD = .45$) general public samples was statistically significant, $t(349) = 5.50$, $p = .001$, (two-tailed). The magnitude of the differences in the means (mean difference = .28, 95% *CI*: .18 to .38) was moderate (eta squared = .08). The difference in instrumental barrier scores between the Nigeria ($M = 2.52$, $SD = .46$) and the UK-based ($M = 2.37$, $SD = .46$) general public samples was also statistically significant, $t(341) = 2.55$, $p = .05$, (two-tailed). The magnitude of the differences in the means (mean difference = .14, 95% *CI*: .03 to .24) was small (eta squared = .02).

Table 4.6 Standard Multiple Regression of Demographic Variables as Predictors of Barriers to accessing formal mental healthcare (Confirmatory study)

	Ideological Barriers			Instrumental Barriers		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Constant	25.70	1.14		24.90	1.28	
Gender	-.49	.31	-.06	.06	.34	.01
Age	.34	.42	.04	.26	.47	.03
Marital Status	.20	.39	.02	-.83	.44	-.09
Educational Status	-.50	.38	-.05	-.61	.42	-.05
Religious Denomination	-.44	.26	-.05	.11	.29	.01
Familiarity	.22	.27	.03	.26	.30	.03
Students vs. Nurses	2.58	.42	.26***	3.51	.47	.31***
Teachers vs. Nurses	1.73	.41	.18***	1.99	.46	.19***
General Public vs. Nurses	1.57	.45	.17**	1.39	.50	.13**

Note * $p < .05$ ** $p < .01$ *** $p < .001$

The demographic variables were used in a standard multiple regression analyses to predict barriers to mental healthcare (see Table 4.6). The linear regression model was statistically significant in the prediction of Ideological Barriers $F(9, 966) = 7.42, p < .001$, and accounted for 6.5% of the variance ($R^2 = .7$). Only occupational group was a significant predictor: students ($\beta = .26, t(975) = 6.20, p < .001$), teachers ($\beta = .18, t(975) = 4.22, p < .001$) and the general public ($\beta = .17, t(975) = 3.49, p < .01$) were significantly more likely to be inhibited by ideological barriers from seeking mental healthcare compared to the nurses. The regression model was also statistically significant in the prediction of Instrumental Barriers $F(9, 943) = 10.76, p < .001$, and accounted for 9.3% of the variance ($R^2 = .09$). Again, only occupational group was a significant predictor: students ($\beta = .31, t(952) = 7.52, p < .001$), teachers ($\beta = .19, t(952) = 4.34, p < .001$) and the general public ($\beta = .13, t(952) = 2.76, p < .01$) were also significantly more likely to be inhibited by instrumental barriers from seeking mental healthcare compared to the nurses.

4.4 Discussion

Striking gaps in formal mental healthcare in sub-Saharan Africa motivated this study which found considerable ideological and instrumental barriers to help-seeking in south-eastern Nigeria. However, contrary to expectation, ideological barriers were significantly perceived more than instrumental barriers in the exploratory study (84.8% vs. 56.6%) and this was confirmed in the confirmatory study (83.3% vs. 57.8%). The finding has a crucial policy implication; it suggests the likelihood that even if facilities and socio-economic status improve, services would likely be underused without greater improvement in people's conceptualization of mental illness. This may explain the disturbing observation that most people with psychological distress receive no mental health treatment even when care is free (Ware et al. (1984; Corrigan, 2004). Socio-cultural and religious norms, beliefs and values shape the manner in which people in this region conceptualise and respond to experiences including psychopathology. As Cauce and colleagues (2002) noted, when salient and valued

social norms are incongruent with formal service use, individuals will inevitably be influenced not to seek help. For instance, socio-cultural norms such as high regard for saving face characteristic of the Igbo culture (cf. Chapter Two) may deviate from the basic principles of formal treatment e.g. disclosure and may inevitably translate into underutilization of professional mental health services. This is exemplified in 74.9% of the respondents indicating that before discussing the mental health problem of someone close to them, it must be someone they can trust with a secret. Similarly 61.3% of the respondents believed that problems such as mental illness are better handled privately because of the shame it could bring. Mental illness constitutes a taboo in this culture and discussions about it go with utmost confidentiality beyond the formality of data protection. The mental health crisis of a family member is among the things that are discussed in hushed tones and it could be very unnerving to be openly identified with a psychiatrist or psychiatric hospitalisation. Drummond and colleagues (2011) discovered that shame was a significant factor dissuading West African refugee women in Australia from seeking help for mental illness. A further cultural twist to the finding was that the more learned among the women felt more shame being associated with mental illness than the less learned which surprised the Australian researchers presumably because they had supposed that education should have a moderating effect on the sense of shame. But this is not to be for a people coming from a culture where social conformity is achieved through the use of 'shaming' (public booing) as a sanction against culturally unacceptable behaviour (Nzewi, 1989). Thus, in their socialisation, shame is associated with deviance such that people of higher status such as the educated would be much more wary of a situation that will bring them shame. Until psychiatric illness is normalized through policies such as deinstitutionalization, to be culturally appropriate, it is pertinent that services proceed with utmost confidentiality in this region.

Cultural inappropriateness of orthodox care as a potential source of barrier to help-seeking in this context could also be demonstrated in terms of therapeutic procedure. For instance, in the

African context, the ability to make quick and accurate diagnoses leading to timely intervention is intrinsic to idea of an expert (a consultant). As Nzewi (1989) noted, extensive and prolonged interrogations are viewed with displeasure and usually generate lack of confidence in the therapeutic process. Thus, the bureaucracy and seemingly superfluous discourse characteristic of conventional psychiatric and psychological therapies would be met with great disappointment. In times of crises, it may seem inappropriate to be kept waiting. This was somewhat portrayed in a study by Keynejad (2008) which explored what inhibits ethnic minority groups from accessing mental health services in London. The study reported that ethnic minorities with multiple needs felt they were always being referred from one agency to another while some felt that any waiting list they would be put on would be so long that it would not be worth seeking help. They considered the seemingly dragging protocols as lack of seriousness on the part of the system. Conversant with the sense of urgency for results in these cultures, traditional and spiritual healers go to the extent of anticipating the complaints of the clients thereby earning their confidence and disposing them positively towards the therapeutic process. Nzewi reported of the experience of the anxious mother of a teenage girl with hysterical paralysis of the legs. As she made to give a lengthy description of her daughter's problems, after a period of seeming inattention by the native healer, he dramatically commands 'stop! How dare you try to seek for the all-seeing eyes and think for the all-knowing mind? You have come to me, let me tell you your problems because I know what they are already.' After some abracadabra and theatricals (anwansi), he proceeds to put together what appears to be a correct picture of the patient's problems to the awe and amazement of his audience. However, he had mostly played on their minds; with his experience, he already had some idea about particular illness symptoms, all he needed was the introductory cue from the discloser and he proceeds to make quick 'authoritative' diagnosis in order to gain the immediate confidence of the clients. Patients' disposition has been demonstrated to facilitate the therapeutic process (Ogrodniczuk, Joyce & Piper, 2005). As noted in Chapter

Three, while the native healers' means of gaining his clients' confidence (anwansi) could be manipulative hence objectionable, the idea underscores the need for care providers in these contexts to demonstrate both professional and cultural competence and adapt these to achieve therapeutic alliance with clients especially as it is a culture where the reputation of the care provider decisively shapes help-seeking behaviour (Asenso-Okyere, 1998).

Socio-cultural norms also influence consumers' preference for setting and for achieving treatment goals and outcomes (Hwang, Myers, Abe-Kim & Ting, 2008) hence there could also be disparate expectations in terms of treatment outcomes. For instance, while in the conventional model (based on individualistic Western culture), the major indicator of recovery rests on overcoming disabilities to meet goals – achieving independence (occupational) (Davidson, Rakfeldt, & Strauss, 2010; Liberman, 2008), in the communalistic African context, the ultimate end to which therapeutic process would aim is to help make a deviant character conform to social norms (behavioural). In the communalistic African culture (where independence is not an ideal but could actually be pathologised), the community (family) naturally becomes the 'hands' and the 'feet' of the disabled person who anticipates this support. This perhaps explains why occupational therapy is not popular in this region with a median rate of 0.01 occupational therapist to 100,000 population (WHO, 2011).

Moreover, the dichotomy between the African (unitary) and Western (dualistic) conception of reality could reflect in people's help-seeking behaviour in this region. As Lambo (1978) observed, the African world-view does not discriminate between the living and non-living, conscious and unconscious, natural and supernatural. These pairs which are conceived of as opposites in the West are realised as unities in Africa. For instance, there is a deep sense of reverence for ancestors who are believed to intervene actively in the affairs of the living. Such vision of reality whereby the seen and the unseen dynamically interrelate contrasts with the dualism of the West such that an experience like hearing of voices which could easily be

pathologised as hallucination in the latter, could, for instance, be welcomed in the former as communication with ancestors - a spiritual gift (Nwoko 2009; Furnham & Igboaka, 2007). The unitary vision of reality is also consistent with the relatively greater somatisation of distress reported in this region whereby psychological problems present in physical symptoms, a tendency associated with seeking treatment for mental health problems in the general medical rather than psychiatric sector (Alegría et al. 1991; Corrigan et al., 2014).

Ranguram and Weiss (2004) had considered that generally, physical illnesses tend to be associated with less stigmas than mental illnesses and this may contribute to high presentation of somatic complaints in patients with underlying mental illnesses in areas where there is low mental health literacy. Somatisation may also be indicative of lacking emotional competence (the ability to identify, understand, describe and manage emotions in an effective manner) which has equally been linked with less successful help-seeking experiences (Ciarrochi & Deane 2001). Here, doctors are consulted mostly for physical symptoms hence psychological distress which may not present in physical inactivity may persist unnoticed. Nwokocha (2010) had observed that language plays an important role in how a person communicates mental health issues or problems and that a person's inability to express their symptoms or a practitioner's inability to understand symptom conceptualization can influence and even change the attitude of the mental health provider.

Furthermore, the Nigerian public generally has poor knowledge about mental disorders, the availability of mental health services and effective treatment outcomes (Jack-Ide & Uys 2013) which potentially undermine help-seeking. For instance, though symptom severity is associated with help-seeking, the conceptualisation of mental illness only in terms of severe psychotic disorders in this region (Igbinomwanhia, James & Omoaregba, 2013; Atilola & Olayiwola, 2011) leads to strong stigmatization of mental illness in general which is a leading barrier to help-seeking. The idea of stigma is illustrated in the findings that 92.9% of the respondents agreed that gossip will spread about someone who gets

mentally ill in the village and 63.8% supposed that it is safer not to get involved with issues like mental illness. Such extreme conceptualization of mental illness connotes 'insanity' which requires hospitalisation/detention and is mostly irremediable. It could therefore lead to reluctance to acknowledge distress as a mental health problem and so seek help (Fuller et al., 2000). It could also imply potential misunderstanding and undermining of other non-psychotic disorders for which help may therefore not be sought. For example, a condition such as ADHD could be interpreted as delinquency in children and handled punitively rather than therapeutically. Possibly, it is with such a notion that clients with subtle onset of mental illness, such as those that prayed continuously, were not recognized in time as mentally ill in a South African study (Mkize & Uys, 2004). In an earlier Ethiopian study, only 12% of respondents considered alcoholism as a serious mental illness for which 66% recommended no treatment or sending the patient to prison (Khandelwal & Workneh 1986).

Lack of mental health literacy is furthermore demonstrated in 65.9% of the respondents thinking that mental health does not exist along a continuum i.e. people are either mad or not mad. Such dichotomous understanding of mental health would not encourage help-seeking especially when symptoms are not debilitating. This was demonstrated in a study with African Americans in the US where many said they did not think they were 'crazy', therefore they did not seek mental health services (Hines-Martin et al. 2003). A similar mindset was reported by a community health worker in a southern African survey; 'We go out to visit these villages and sometimes we find people who feel that we are wasting their time because they believe that health only needs attention when it is giving problems' (Obioha & Molale, 2011). Such notions are further reinforced in the Nigerian context where the gravity of psychiatric illness is judged on behavioural grounds (Binitie 1970) - a conception corroborated by 81.3% of the respondents who indicated that mental illness is recognizable only when the individual starts misbehaving. Holding such idioms of distress could potentially delay help-seeking since overt behavioural symptoms could manifest belatedly or even be entirely lacking in the course of a disorder. This is somewhat

underscored in 50% of the respondents conceding that mental illness is not usually noticed on time. Moreover, 63.8% of the respondents submitted that different causal factors for mental illness mean confusion regarding where to seek help while half (50.7%) of the respondents categorically stated that they are not sure of where to seek help. These reflect the observation that social networks in these contexts delay in recognizing first signs of mental illness hence may not inform prompt intervention. As Mkize and Uys (2004) rightly noted, in the traditional African context, the social network assesses the severity of one's sickness by the extent of the person's activity; if a sick person continues to work, then the sickness is minor. The sickness is considered serious mostly when the patient is bedridden. Recognition of symptom is the gateway to help-seeking as action taken regarding sickness depends on whether the communities under study perceive the condition as a major health problem.

Furthermore, as noted in Chapter Three, the sudden onset of psychotic conditions that could come with bizarre symptoms and at the prime of life usually rattles the uninformed families. Fuelled by the deeply religious worldview of the people, such 'strange' occurrence 'logically' attracts supernatural attribution with the immediate response usually being recourse to the spiritual help pathway. Such views of psychopathology could equally discount the effectiveness of conventional psychiatry. Similarly, a common element in the African belief system is that mental and physical illness can also result from disequilibrium in the harmony between an individual and the cosmos (cf. Chapter One). As earlier mentioned, the Igbo people believe, for instance, that breaking of taboos and disruptive behaviours are punishable by ill-health and misfortunes. Attributions of personal causality are followed by judgments of responsibility. There is, for instance, an observed increase in causally linking mental illness to the use of illicit drugs and alcohol in most of Sub-Saharan Africa which is viewed negatively and linked to the moral failings on the part of the user (Aghukwa, 2009a; Crabb, 2012). Reinforced by the strong belief of these societies in

retributive justice, when mental illness is associated with self-destructive behaviour, sufferers could be condemned as paying for their 'sins' which risks non-medical treatment, discrimination, rejection and even maltreatment by the public including healthcare professionals.

Another important medium through which lacking in mental health literacy is demonstrated is prognostic pessimism. Not few Nigerians believe that mental illness is incurable and ultimately terminal (Ewhrudjakpor, 2009; Aghukwa 2009b). Entrenched pessimism regarding the course of mental illness is captured in a popular Igbo proverb 'agwosia onye ara, adighi agwo ya ntamu' - however well a mad man is cured, his tendency to soliloquise remains i.e. full symptom remission is impossible, a view endorsed by 46.4% of the respondents. Only 9% of doctors in a comparable south-western Nigerian study believed that mental illness could be cured (Adewuya & Oguntade 2007). As beliefs about effectiveness of treatment and services influence subsequent treatment behaviour (Dosreis et al. 2009), such myths of incurability could discourage help-seeking as futile - a waste of time and resources.

Most mental disorders can be effectively treated or managed but having evidence-based treatments available is not enough if the public does not perceive conventional psychiatric interventions as effective. Research has demonstrated that increasing public understanding of mental health conditions and awareness that effective treatment is available is critical in improving health-seeking behaviour (Wang, et al., 2007; Patel et al., 2007). Such campaigns would help to promote prompt help-seeking thereby reducing morbidity and disability. Public health campaigns are therefore necessary to enlighten the public about the available treatments for mental health problems that have yielded some promising results. Controlled evaluation showed that 10 weeks after the presentations given by trained GPs, students' intentions to consult a GP for physical and psychological problems significantly increased and their barriers to engaging with a GP had significantly decreased (Wilson, Bignell &

Clancy, 2003). Preliminary evaluation of mental health first-aid training courses for the general public also showed that such public courses may be useful in improving mental health literacy levels (Kitchener & Jorm, 2002). Education also helps in the normalization of mental illness (cf. Chapter Two) hence greater confidence to seek help following de-stigmatisation. Improving mental health literacy of the predominantly rural communities of traditionalist societies could also focus on changing attitudes such as self-reliance and preference for informal help. As somatisation is a common idiom of distress in this culture, efforts to enlighten the public about symptoms could be focused on the somatic presentation of underlying symptoms. Given that initial recognition and response to mental health problems generally takes place in the community and the significant influence of the social networks, in the design of mental health programmes, the family should be empowered with knowledge and mechanism of referral. As the onset of psychosis can be unforeseen with unnerving symptoms, a general awareness about the disorder can prepare people/families for the unexpected, making them more confident to take more rational decisions especially faced with the confusion of unsolicited prescriptions from the social network.

Experience of mental healthcare in Nigeria would more likely discourage than encourage users to seek conventional psychiatric healthcare. Culturally, psychiatric treatment is a potentially difficult, embarrassing, and overall risky enterprise with respect to the individual's sense of self-worth and environmental homeostasis owing to the debilitating stigma surrounding mental illness. Disturbingly, as Sartorius (2002) suggested, the stigma of mental illness begins with the attitudes and behaviour of medical professionals (iatrogenic stigma) which is most detrimental because of the belief that if a specialist says or thinks it is bad then 'it is bad'. Surveys of medical staff in Nigeria show that in spite of their relatively impressive mental health literacy, they still harbour deeply rooted cultural beliefs that discriminate against those with mental illness resulting in their placing emphasis on custodial care and opposing care in community (Aghukwa, 2009a; Ewghrudjakpor, 2009;

Adewuya, & Oguntade, 2007). Sixty-four per cent of medical doctors in selected health institutions in Nigeria preferred high social distance from people with mental illness (Adewuya & Oguntade, 2007). These would be unwilling to share a room with someone with mental illness which suggests unwillingness to offer medical consultation which usually takes place in consulting enclosures. In the study by Aghukwa (2009a), almost two-thirds of medical staff (64.1%) would feel fearful at the thought of having people with mental problems admitted within the hospital and more than half (53.0%) would not wish to have their place of work next door to the psychiatric wards. These corroborate the findings of our study on attitudes to mental illness (cf. Chapter Two) whereby 79.3% of the nurses would not want close association with people with mental illness while a third (35.4%) would be unwilling to relate with them even from a distance and more than half (58.6%) supported authoritarian attitude that sees them as different. Furthermore, the association of mental illness with the abuse of substances in this region which often provokes moralistic and stereotyping attitudes in health and social care professionals also results in punitive, rejecting responses and interaction characterised by suspicion, mistrust and avoidance. Disturbingly, iatrogenic stigma persists in these contexts even in the absence of aberrant behaviour as exemplified by the findings in Chapter Two whereby the negative responses of nurses prevailed even when the question on attitudes was asked in relation to people already cured of mental illness.

This study also indicates that more than half of the respondents could be constrained by instrumental barriers from seeking help for mental illness. Nigeria has generally very poor mental health infrastructure with a total number of 0.005 mental hospitals, 2.5 psychiatric beds, 0.06 psychiatrists and 0.02 psychologists per 100,000 population (WHO, 2011). There are about 150 psychiatrists for 170 million people (Kakuma et al., 2011). The Primary Health Care (PHC) system forms the bedrock of Nigeria's health Policy (Federal Ministry of Health, 1992). It is based on the Alma Ata Declaration of 1978 in

Kazakhstan under the auspices of the World Health Organisation and UNICEF (WHO, 1978). By conceptualization, primary care is expected to offer first contact, provide comprehensive, continuous, and coordinated service for persons with health conditions and also display the capacity for prompt referrals to a higher level of care (Gureje et al., 2015). The idea is to support the care of the most common diseases found in the community, irrespective of their complexity, using scientifically sound and appropriate technology and making this service universally accessible to individuals and families in the community through their full participation (Awojobi, 2011). The PHC structure is made up of interdependent sections such as community health workers, non-governmental organizations (NGOs), nurses, support groups and members of the community in general who work together to fulfill the functions necessary for meeting the health needs of the society as a whole.

In line with WHO directive, the Nigerian Federal Ministry of Health (FMOH) added mental health as the ninth component of the PHC in 1989, identifying this as the only realistic way mental health services could reach the population (Federal Ministry of Health, 1991). The perceived advantages of PHC include relative availability, affordability, but most importantly that patients from the community are treated by people they can relate to. One of the early large-scale comprehensive evaluation of the Primary Health Care service delivery in the developing world carried out by Primary Health Care Operations Research (PRICOR), a USAID-financed project between 1985 - 1992 and spanning 12 countries uncovered severe deficiencies in the diagnosis, treatment, and counselling of patients as well as in the supervision of health workers (De Geyndt, 1995). Community satisfaction with primary health services was low, especially regarding the interpersonal skills of health center staff. To improve healthcare supposedly through better financing of the primary care system, user fees were introduced following the Bamako Initiative of 1987 (UNICEF, 1988). Consequently, cost and perceived low quality of care became some of the main reasons why people did not attend primary health care

services in cases of illness.

Moreover, lack of political will, poor leadership and corruption have continually been the bane of the Nigerian system against the backdrop of the wider Africa continent bedeviled by crises - internal strife, political instability, malnutrition, communicable diseases, poor manpower, poverty etc. With basic necessities of life under threat including other aspects of the health sector competing for attention such as the “double epidemic” of high infant and maternal mortality rates, and the HIV epidemic, it comes as no surprise that mental health concerns had not been a priority for governments and policy makers in the African continent (Gureje & Alem, 2000; WHO, 2001a). As earlier noted, while the WHO recommended 5% of the Gross Domestic Product (GDP) to be allocated for mental health, less than 3% of GDP is spent on health in Nigeria and of this less than 1% is allocated to mental healthcare. Consequently, many years after its introduction into the Primary Health Care (PHC), mental healthcare appears non-existent at this basic level of care and is scarcely existent at the secondary level (Lawani, 2008). The provision of care is thus limited from source. And this is even with the escalating mental health needs due to urbanisation, breakdown of traditional family structures and political and economic instability.

The resultant system of paying out-of-pocket, without insurance cover, means that many families find it hard to afford care for their loved ones especially for chronic cases. This results in 70% of Nigeria’s over 150 million people lacking access to modern mental health services (Omigbodun, 2001) while an estimated £1 billion is spent annually by the politicians and the affluent on medical trips abroad (Fabiya, 2013). The consequences of this include; increased self-medication, patronage of alternative sources including private health facilities, drug vendors and traditional healers (Nsereko et al., 2011; Uzochukwu & Onwujekwe, 2004). Murali and Oyebode (2004) had observed how poverty could lead to the taking of maladaptive behaviours or questionable pathways, not with harmful intent but as coping behaviours to provide comfort or relief from stressful life. While drug peddlers, drug

store operators and traditional and faith healers may provide services that are closer to the people and may be cheaper at the short run than services from regular health care providers (Asenso-Okyere, Anum, Osei-Akoto & Adukonu, 1998), adverse consequences of these measures include; over-dosing, problems of resistance, delay in arriving at standardized medical facility and discontinuing with therapy (Deressa, Ali & Enqusellassie, 2003; McCombie, 2002, Awojobi, 2011; Gureje & Lasebikan, 2006).

Furthermore, with policies that locate mental health institutions mainly in urban areas and big cities, the majority of Nigeria's population living in poverty in rural areas lack access to modern mental health services due to poor knowledge of available services, high cost of service including cost of transport and a negative view of the care system as elitist. Moreover, very few qualified practitioners would be ready to accept to work in the rural areas that lack basic infrastructure, equipment and social amenities. Thus, the majority of psychiatric presentations seen by clinicians are in primary care settings clearly not well equipped to be the main source of mental health care for people with severe mental disorders. In a related South-African study, staff in primary care lacked the skill to identify psychological distress, for instance when clients present physical symptomatology (Mkize & Uys, 2004). Another South African study reported significant problem of non-detection in primary care whereby many with psychiatric disorders are either undiagnosed or misdiagnosed thus inadequately treated (Freeman, 1992). Lacking the skills means lacking in confidence hence many of the primary care providers are basically not comfortable dealing with mental healthcare (Geller, 1999). Primary health workers in Africa themselves face many challenges that furthermore inhibit their productivity such as not receiving incentives for the work they do, the often uncooperative disposition of some community members including community leaders and lacking the basic tools of work such as transport to reach remote areas which limits the space of coverage. Lack of incentives could translate to lack of commitment.

The PHC is designed to offer treatment and care in a continuum that is supported by a referral system (Obioha & Molale, 2011) but in the Nigerian context official referral procedures for referring persons from primary care to secondary/tertiary care and vice versa do not exist (WHO, 2011). There is also lack of coordination of mental health services across the tertiary, secondary and primary tiers of the health system with the result that needs do not determine the extent of service provided. For example, a national survey found that a disproportionate number of persons with mild mental health conditions received specialist care while those with more severe conditions continue to receive inadequate care at the primary care level (Wang et al., 2007). Lack of specialist mental health care in the system implies that communities would increasingly depend more on general practitioners (GPs). Yet, a lot of factors including; lack of training and experience in psychiatry, absence of incentives, poor communications between the general practitioners and psychiatrists, non-availability of medication and contribute to GPs not being in the position to provide optimal services regulations limiting the autonomy of general practitioners in managing mental disorders (Gater et al., 2005). GPs' low therapeutic commitment to this client group could also be informed by the stigmatized image of the mental patient and the myth of incurability.

Ultimately therefore, psychiatric facilities in Nigeria are basically limited to tertiary institutions. Yet, provision of care at this level is also undermined by systemic, infrastructural and logistical constraints. For instance, unevenly scattered around Nigeria, a country of over 150 million people are 31 psychiatric facilities, all situated in urban areas and virtually having no synergy with health facilities in the community such as the district general hospital in each LGA and the 4 to 7 PHC centres within a Local Government Area, each of which serve 10,000 to 30,000 people (Olayinka & Omigbodun, 2001). Among these are the only eight federal owned and managed neuro-psychiatric hospitals situated in city centres; Sokoto (north-west), Maiduguri (north-east), Kaduna (north-central), Calabar (south-south), Benin (south-south), Abeokuta (south-west), Yaba, Lagos (south-west) and Enugu (south-east).

Others are psychiatric units in state central hospitals and in Universities with college of health sciences. These limited under-equipped mental health institutions are riddled with and disrupted by persistent staff strike actions that encourage 'brain drain' evident in the migration of professionals such as psychiatrists to seek for job overseas with the result that there are more Nigerian psychiatrists in Britain alone than in Nigeria (Ewhrudjakpor, 2010a).

A recent report (Njoku, 2015) described the Neuropsychiatric Hospital in a Enugu (part of the south-eastern Nigeria region under survey) as battlefield with a lingering crisis between the management and workers of the institution which has crippled operations resulting in the main entrance to the hospital been under lock and key for over three years and the hospital premises being described as home to uncompleted and abandoned projects with inadequate wards to accommodate referred patients. The workers complaint against the management border on alleged embezzlement, corruption, mismanagement and abuse of office including; undue delay of promotion exercises, non-payment of promotion arrears, non-payment of teaching allowance, non-annual staff salary increment, double taxation of staff; suspension, demotion and interdiction of union members, selective sponsorship of staff to international conferences and workshops, non-availability of water and electricity, non-availability of work materials including reagents for the laboratories and drugs for pharmacies resulting in patients resorting to roadside pharmacies for prescriptions. Reporting about the corruption in the system, the workers union in a statement declared "If you come to our hospital, corruption stinks; it smells and you can still perceive it.... Those that died and workers who moved to other places of work are still on the pay roll of the hospital and only the MD (Managing Director) and the Chief Accountant know who collects their salaries." Prohibitive user fees also contribute to the diminishing access to care in these tertiary health institutions (Awojobi, 2011). Moreover, the practice of public doctors running private clinics alongside their public role potentially compromises the system with the possibility of doctors having divided loyalty

and a situation whereby the doctors could exploit public facilities as feeder systems for their private practices.

As earlier indicated (cf. Chapter One), the Igbo people subsist in this state of affairs, additionally with the scar of a persecuted minority following their loss to the Nigerian state in a civil war the price of which they believe they are still paying in exceptionally more limited federal government presence in the region. Schlosser (2006) had noted that the aetiology of mental illness could also be linked with membership of a supposedly persecuted minority and that self-stigmatisation arising as a consequence of enduring impact of discrimination and persecution (real or imagined) ultimately manifests as mental ill health. Achebe (2012) notes that the post-war pledge to rehabilitate and reintegrate the Igbo people into the Nigerian state was mostly a sham though it led to the establishment of the only federal owned neuropsychiatric hospital in Enugu to cater for the casualties of war. The significance of recognizing such traumatic history for effective psychological intervention in the wider African context that is bedeviled by past and present traumatic experiences including colonial imperialism, Western missionary assaults, economic turmoil, and socio-cultural problems had been noted (Odejide, Oyewunmi & Ohaeri, 1989).

The Primary Healthcare Care initiative is meant to decentralise healthcare down to community level but the absence of effective community-based mental health services puts additional pressure on the already stretched tertiary facilities. Moreover, the logistics of accessing tertiary-based care in urban centers can be additionally more costly from rural communities. Having to trek or travel long distances to access care entails taking time away from trade, work or home responsibilities. In a related study of south-southern Nigeria (Jack-Ide, Uys & Middleton, 2013), the distance travelled to access service was of great concern resulting in many families not sustaining or continuing with treatment. It has been shown that those living closer to services demonstrate shorter delays in arriving at services (Gater et al., 1991) which suggests that decentralizing psychiatric services and providing local access

might diminish delays. Furthermore, given the fact that initial recognition and response to mental health problems generally takes place in the community (Angermeyer, Matschinger & Riedel-Heller 2001), there is need for the integration of quality mental health services into primary health care as a way of facilitating early detection and intervention for mental disorders in keeping with the ideals of the Alma-Ata declaration that inspired the Primary Health Care model.

The WHO (2008) makes the case that integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental healthcare they need. Since mental and physical health problems are interwoven and many people suffer from both physical and mental health problems, integrated primary care services would help to ensure that people are treated in holistic manner - meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders. With such a model, patients would be handled by staff who know their cultural background and context which would forestall some of the therapeutic dissonance that usually arise when patients are treated outside their socio-cultural milieu by people who are often not familiar with the culture and the situation in which the patients live. An integrated model would also support people to access mental health services in close proximity to their homes which would help to keep families together – an ideal in communitarian societies. Primary care for mental health would also facilitate community outreach and mental health promotion, as well as long term monitoring and management of affected individuals. Mental health services delivered in primary care holds more promise for the minimization of stigma and discrimination as the effects of institutional treatment would be forestalled. Trained PHC staff can provide preventive interventions that do not necessarily need the expertise of the mental health expert hence the model would make for a generally cost-effective care system by curbing the wasteful deployment of highly specialized professionals who may end up treating milder forms of illness that could be very well handled

by practitioners at primary care centres.

Integration of mental health services in the primary care needs a system of education and enlightenment to succeed. The WHO (2008) recognized that certain skills and competencies are required to effectively assess, diagnose, treat, support and refer people with mental disorders and that it is essential that primary care workers are adequately equipped with these skills and competences in their mental health work. From an international study of mental health patients presenting in PHC services in developing countries, it was demonstrated that it is possible to train general and PHC staff in methods of treatment of several mental disorders and that staff so trained can provide useful and effective service to people contacting the services (Gater et al., 1991). It needs to be recognised that inadequately trained PHC staff that are lacking especially in referral skills could do more harm than good in the care process. For instance, Fujisawa and colleagues (2008) discovered that mental health professionals other than psychiatrists that were consulted en route psychiatric care delayed patients referral to the psychiatric system ironically more than the non-health care professionals such as social workers. This is evocative of the saying that half education is dangerous. Perhaps, armed with their limited knowledge, they were tempted to push their luck further with the patients instead of making prompt referrals while those lacking in any knowledge, recognising their total handicap, promptly referred patients to the specialists. PHC staff need therefore to learn referral skills which they need to readily apply as part of professional competence, not as demonstration of incompetence.

The WHO further notes that integration is most successful when mental health is incorporated into health policy and legislative frameworks and supported by senior leadership, adequate resources and ongoing governance. It is therefore important that governments at the federal and local levels demonstrate political will and commitment to the policy through adequate financing and provision of opportunities for training of staff including scholarships schemes. To succeed, integration of mental health services into primary care also needs to be

accompanied by complementary services, particularly secondary care components to which primary care workers can turn to referrals, support, and supervision. It is therefore a disturbing observation (Sartorius, 1998) that psychiatrists who have the training to provide these complementary services feel threatened that their job would be usurped and their income diminished with the integration of mental healthcare into PHC and taking on board of GPs hence the reluctance of many towards the integration model and delegation of mental health tasks to general health care workers. These therefore constitute an important demography for targeted advocacy necessary to sensitize stakeholders including national and local political leadership, health authorities, management and primary care workers about the significance of such cost-effective model of mental healthcare especially considering the prevalence of mental disorders, the burden they impose if left untreated, the human rights violations that often occur in psychiatric hospitals and the positive impact of well managed primary care-based treatments.

Ultimately, the ideal of complementary model of care whereby the alternative care providers (faith and traditional healers) could work alongside orthodox practitioners (cf. Chapter Three) is most feasible with the primary care model which is designed to operate at the basic social structure as the alternative models. Evidence now abound from the Nigerian context that primary health workers can be trained to acquire skills that would enable them to deliver both psychological and pharmacological treatments (Makanjuola et al., 2012; Odejide et al., 2002). Recently, Gureje and colleagues (2015) successfully conducted a pilot programme to integrate mental health services into primary health care in Nigeria using the WHO Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) contextualized for the local setting. The programme was implemented over 18 months in 8 selected local government areas (LGAs) in Osun state (south-western Nigeria). A well supervised cascade training model was utilized for the programme with Master Trainers providing training for the Facilitators, who in turn conducted several rounds of training for front-line primary health care workers. A total of 198

primary care workers, from 68 primary care clinics, drawn from 8 Local Government Areas with a combined population of 966,714 were trained in the detection and management of mental, neurological and substance use (MNS) disorders including moderate to severe major depression, psychosis, epilepsy, and alcohol use disorders. The study reported a marked improvement in the knowledge and skills of the health workers following training and also a significant increase in the numbers of persons identified and treated for MNS disorders, and in the number of referrals.

However, the call to integrate mental healthcare into primary care is not without some concerns; it has been feared that integration may impose Western medical treatment models, undermine other healthcare sectors such as the district or secondary tier levels and could result in a failure to address and strengthen community rehabilitation (Sartorius, 2014; Ventevogel, 2014). Experience from other sub-Saharan African countries have also raised concerns about poor policy implementation, shortage of health professionals to drive and support the process, poor community engagement and mobilization, and lack of medications (Petersen et al., 2011; Bhana et al., 2010).

The finding of the study that the UK-based respondents would be potentially less constrained by both ideological and instrumental barriers than the Nigeria-based respondents is expected given the possible effect of acculturation (cf. Chapter One) and better and more accessible healthcare system. Yet, that as much as almost two-thirds (63.9%) of the sample could still be inhibited by ideological barriers is indicative of the presence of a more fundamental inhibitive factor and that acculturation might not be all the answers that are needed for the immigrant (Igbo) community in the UK to have mental healthcare tailored to their needs. Moreover, besides the fact that acculturation itself demands changes in orientation which may engender its own conflicts, studies have indeed shown that higher orientation towards the host culture has not always been found to be an indicator of positive outcomes among immigrants. For instance, Clark and Hofsess (1998) had found that an increased level of

acculturation towards the host culture was associated with higher rates of depression, drug use, and mortality. A marginalized style of acculturation has also been associated with symptoms such as anxiety and depression (Neto, 2002). Most revealing however is the finding that immigrants who identified with their native cultures were found to have more favourable psychological adjustments and this is after controlling for personality and self-efficacy differences (Chen et al., 2008). This shows that aside the dynamics of acculturation, immigrants need to retain some form of autonomy as they contend with the systems of the host culture which need to demonstrate cultural sensitivity in their care.

Health professionals' lack of cultural competency including adequate knowledge and awareness of the impact of cultural differences in the assessment and treatment of mental illness constitute additional barriers to the adequate accessing of mental health care by immigrants (Gaines, 1998; Idemudia, 2004). The cultural understanding, meanings, and symbols that immigrants bring with them are critical in addressing immigrants' experiences. These were accentuated in the aforementioned very informative study by Keynejad (2008) that explored the barriers that constrain ethnic minority groups from adequately accessing mental healthcare in London. Ethnic minorities in the study saw psychotic symptoms as spiritual and identified faith leaders as the appropriate person to seek help from. They were quite suspicious of mental health services and were unconvinced that medication would be of any use. Many felt their problems to be social rather than medical while others did not feel primary care workers had any expertise in mental health. The study further identified that gossip, negative stereotypes, social rejection and lack of understanding all made it harder for people to identify symptoms as a problem. On the other hand, many were unaware of the available help which is a key indicator of instrumental barrier and may be a factor in our finding that over a third of the UK-based respondents could be constrained by instrumental barriers even amidst a relatively well developed healthcare system. The study also reported that those who did find services sometimes found them to be far better than they had anticipated which shows that people with limited information may overestimate the difficulty associated with accessing services. Furthermore, the study

reported that there was mistrust of the mental health system as people said they expected primary care practitioners not to have enough time to listen to them, to prescribe antidepressants as a default solution or be dismissive of their complaints. Users in the study felt their views were rarely consulted, yet many were not equipped with the procedures for registering their complaints should they feel dissatisfied with services. Studies indicate that the experience or anticipation of unfair and unequal treatment in mental health services generate deeply entrenched mistrust within minority communities and act as a powerful barrier to accessing care and treatment (Keating et al. 2002; Edge & Rogers 2005; Keating 2007).

As a way forward, the respondents in the study by Keynejad (2008) wanted services to be delivered more holistically in the form of complementary model with alternative therapies. Those not using services wanted more information about the help available in their own languages while those using services wanted more information about their medication and treatment made available in their own languages. Following the study, the author suggested some steps with the potential to improve ethnic minorities' perceptions of mental health and the promise of their likelihood of taking the crucial step of seeking help as early on in their illness as possible. These include; 1. Education and Promotion that aims at myth-busting and raising the profile and accessibility of primary care. 2. Provision of Holistic Healthcare such as low-intensity talking therapies delivered by ethnically diverse therapists. 3. Greater involvement of ethnic minority service users in service user committees as well as one-off events to consult service users and carers from specific ethnic minority communities in service planning and design. 4. Establishment of a system that investigates ethnic minority carers' needs and determine gaps in the service. 5. Cultural competence training to be delivered to a group of ethnically diverse service users and clinicians and provision of Chaplaincy Services across the diversity of ethnic groups and the breadth of faiths. 6. Development of Polyclinics to take on board the suggestions of service users towards the

development of an integrated model that will incorporate faith, physical and mental health services.

Although this is a somewhat contentious issue, the NHS does currently provide some of these therapies and they may be a crucial way of engaging ethnic minority groups by illustrating that services go beyond the Eurocentric medical model. Though National interest in the mental health of ethnic minorities seems to have increased in the past decade, the human service professions have historically failed to meet the particular mental health needs of various underserved ethnic groups (Baruth & Manning, 2003). It is of particular concern that empirical investigations of mental health issues pertaining to Africans continue to lag behind in comparison to the volume of research conducted on other minority groups (Betancourt, et al., 2000). The non-adaptation of services to the needs of African immigrants and their unique struggles of adapting to a new culture and belief system impose additional barriers for those of them that suffer with mental illnesses and need treatment.

That nurses demonstrated significantly less perceived ideological and instrumental barriers compared to the non-nursing occupational groups is expected given that the training and experience of nurses are supposed to help them burst myths surrounding mental illness on the one hand and also give them advantage in terms of the pragmatics of accessing care. This furthermore underscores the importance of improving the mental health literacy of the people as the key to emancipating them from ideological barriers that could inhibit them from promptly seeking mental healthcare which leads to worsened clinical and social outcomes. However, that students significantly contributed to ideological barriers is disturbing given that the onset of serious mental illness such as schizophrenia is mostly during the student years of adolescence and young adulthood (Kleintjes et al. 2010). It agrees with the consistent research finding that the gap in help-seeking for mental illness is most striking in young people (Rickwood, Deane & Wilson 2007; Zachrisson, Rodje & Mykletun 2006; SAMHSA, 2012). A systematic review of literature (Gulliver, Griffiths & Christensen, 2010) confirms

the leading barriers to young people's accessing of mental health services to be mostly ideological: stigma, embarrassment, lack of emotional competence and mental health literacy, concern with confidentiality and trust, and resort to self-help. Young adults also demonstrate more pessimism about treatment and prognosis (Kobau et al., 2010). It is to be expected that the embarrassment and social isolation that come with stigma will be of exceptional concern for the young student in an age bracket that prizes social and peer acceptance hence the reluctance to self-disclose, obsession with confidentiality and recourse to self-help. Secondly, as youth is stereotyped with anti-social behaviours, there is the likelihood that a society that causally links mental illness to substance abuse and moral failings could be quick to deplore the mental illness of the young as a product of self-destructive behaviour. This could discourage young people from disclosing mental health challenges as a system of adult providers would not earn their confidence. It could also explain why young people show greater help-seeking intentions towards trusted sources such as friends who share common experiences with them (Rickwood, Deane & Wilson, 2007; Barker, Olukoya & Aggleton, 2005). It was observed however, that young people who have established relationships with health professionals were likely to seek help in the future (Rickwood, Deane, Wilson & Ciarrochi, 2005). Interpersonal confidence is a necessary ingredient of therapy more so for the wary youth to freely relay painful and personal private information about one's life and health and accepting guidance through life changes that are difficult.

The failure to elicit the views of young people on the subject of mental health has been well documented (Department of Health [DOH], 2005; Parish, 2004). Disturbingly too, the review by Gulliver and colleagues (2010) also found that there is a paucity of high quality research in the area of help-seeking determinants for young people. As an age bracket with the most risk of onset of serious mental illness, this group would benefit from targeted interventions. The World Psychiatric Association has underscored the

necessity of selecting a target group when implementing educational activities, and that more specific definition of the target group facilitates assessment of programme efficacy (WPA, 2005). Since stigma reduction during the adolescent years increase adolescents' comfort in discussing mental disorders (Pinto-Foltz & Logsdon, 2009), mental health education (which helps to normalise mental illness thereby reducing stigma) will be a promising intervention. Following educational intervention, young people believed that people with mental illness were less distinct, less of a threat and less shameful, without the need to keep them at a safe distance, restrict their activities and hide their mental illness (Pitre et al., 2007).

The school has proved to be an auspicious platform for health promotion schemes (Randhawa & Stein, 2007; Lauria-Horner et al., 2004; Gale, 2001; Pinfold et al., 2003). Given the necessity of intervention at this stage, radical measures such as the inclusion of mental health literacy as part of school curriculum would be decisive. Interventions in schools facilitating encounters between students and people with schizophrenia have also proved to be particularly promising (Schulze et al., 2003; see also contact theory Chapter Two). However, it is ironic that teachers who should be instrumental in the improvement of mental health literacy through the school system also contributed significantly to the perception of ideological barriers. This is all the more disturbing as it suggests the possibility that ignorance regarding mental illness is being recycled in the school system. It is therefore much more imperative that teachers are targeted for mental health education not only for their own mental healthcare (which is very crucial given their vulnerability in doing one of the most tasking but least remunerated jobs in Nigeria) but also because of the ideological influence they could have over pupils.

The finding that females could be constrained more than males by ideological barriers seems atypical and contrary to expectation especially as females generally appear more positive towards mental illness (see Chapter Two on attitudes) and research indicates that females are

also generally more favourably disposed to seeking mental healthcare than males (Mackenzie, Gekoski & Kno, 2006; ten Have et al., 2009; Judd, Komiti & Jackson, 2008). However, besides the fact that females demonstrated more supernatural attribution for mental illness (cf. Chapter One) which discounts the effectiveness of conventional psychiatry (cf. Chapter three) and is consequently associated with less compliance with the conventional treatment model (Rose, 2010; Jorm, 2000; Razali et al., 1996; Kurihara et al., 2006), gender effect appears to be culturally mediated. Studies that associate females with greater disposition to seeking mental healthcare are mostly with Western samples. Most of the studies from traditionalist cultures of the developing world including Nigeria report otherwise (Gilbert et al., 2007, Lahariya et al., 2010; Aniebue & Ekwueme, 2009). This might be attributed to the prevailing gender bias in these societies. For instance, help-seeking could cause potential damage to females' marital prospects in these cultures as earlier highlighted with Arab cultures with the likelihood of divorce or husbands taking on second, polygamous wives. In the Igbo society under survey, while a significantly impaired man or one with residual psychotic symptoms could easily contract marriage, marriage is almost effectively foreclosed for a woman marked as 'mentally ill'. This situation is not helped by the conceptualisation of mental illness only in terms of severe psychotic disorder in this society. The gender bias is further revealed in men and women placing differential emphasis on the importance of the beliefs and values of their social networks; whereas women who sought help were more likely to report that family members would not get upset on learning about it, there was no relationship between men's beliefs about family members' opinions and their use of therapy (Leaf, Livingston & Tischler, 1986) which demonstrates the relatively greater impediment of women in these communities regarding seeking mental healthcare. Taking cognisance of gender differences in mental health including risk and help-seeking would ensure more 'gender sensitive approach' in mental health policies.

The study also found that low education significantly contributed to the perception of instrumental barriers. Access to information is vital for awareness and actual accessing of available services and those with more education that invariably have better access to information demonstrate higher rates of help-seeking and treatment utilisation (Al-Rowaie 2005). In a typical south-eastern Nigerian village setting, information is disseminated to the people through limited channels such as church gatherings, town criers and mobile public address systems. The more educated people who can read and additionally have a better grasp of English (the official medium of communication), have wider access to information including from the print and electronic media. People with limited information on the available conventional mental health services may overestimate their inaccessibility. On the other hand, going by the human capital theory, education raises human capital such that a strong linear relationship between education and earnings is envisaged (Tilak, 2002). Invariably, those with low education are also more likely to lack the material resources to access services. With a very low Tertiary Gross Enrolment ratio of 10% (UNESCO Institute for Statistics, 2005), the majority of Nigerians (90%) in the lower education category are therefore at risk of being impeded by instrumental barriers from accessing mental health care. This justifies the recommendation by WHO to scale up mental health services in Low and Medium income countries (WHO, 2010). This would involve making services available to more people who need it, increasing the range and variety of services offered, ensuring that services are culturally appropriate or well adapted to contexts and sustaining these services through effective policy, implementation and financing.

4.1.1 Conclusion

This study underscored the very inhibitive ideological and instrumental barriers to accessing formal psychiatric healthcare in this region but also revealed the primacy of ideological barriers which could help to prioritise intervention. It shows that lack of facilities and material poverty which are easily perceived as the major barriers to good

mental healthcare in the region and for which the system (state) is mostly held culpable are after all not the most potentially inhibitive barriers to accessing mental healthcare but ideological impediments which follow mainly from culturally informed conceptualisation of mental illness and lacking in mental health knowledge. Thus, it demonstrates that determining the conceptualization of mental illness could help in unravelling the reasons for the underutilization of mental health services. The finding also underscores the significance of delivering culturally appropriate services and cultural competency in mental health service delivery. That nurses demonstrate the potential to be less encumbered by both perceived ideological and instrumental barriers to accessing mental healthcare demonstrates the prospect of mental health education in improving attitude and skills for help-seeking. This is particularly pertinent for demographics such as the young (students), females, those with low education and teachers that contributed relatively more to the perception of these barriers.

Chapter Five

Relationships between Causal Beliefs, Attitudes, Preferred Treatment Pathways and Perceived Barriers to Help-seeking

5.1 Relationships between the four dimensions of mental illness explored using Pearson product-moment correlation coefficient.

Systematic associations were found between the four dimensions of mental illness studied. There was a strong positive relationship between the endorsement of supernatural causations and the preference for the spiritual treatment pathway, $r = .56$, $n = 1019$, $p < .001$. There was also a moderate positive relationship between the endorsement of supernatural causations and the preference for the traditional treatment pathway, $r = .48$, $n = 1004$, $p < .001$. However, there was a weak negative relationship between the endorsement of supernatural causations and the preference for the conventional psychiatric treatment pathway, $r = -.11$, $n = 1030$, $p < .01$. On the other hand, there was a weak positive relationship between the endorsement of psychosocial ($r = .16$, $n = 969$, $p < .001$) and biological ($r = .10$, $n = 1026$, $p < .01$) causations and the preference for the conventional psychiatric treatment pathway. There was also a weak positive relationship between the endorsement of psychosocial causation and the preference for the traditional treatment pathway, $r = .14$, $n = 942$, $p < .001$.

There was a moderate positive relationship between the endorsement of supernatural causations and perceived ideological barriers, $r = .35$, $n = 1009$, $p < .001$. There was also a weak positive relationship between the endorsement of supernatural causations and perceived instrumental barriers, $r = .23$, $n = 985$, $p < .001$. There was a moderate positive relationship between perceived ideological ($r = .39$, $n = 1015$, $p < .001$) and instrumental ($r = .41$, $n = 986$, $p < .001$) barriers and preference for the traditional treatment pathway. There was also a moderate positive relationship between perceived ideological ($r = .40$, $n = 1023$, $p < .001$) and instrumental ($r = .34$, $n = 999$, $p < .001$) barriers and preference for the spiritual treatment pathway. However, there was a weak negative relationship between perceived instrumental barriers and preference for the conventional psychiatric treatment pathway ($r = -.13$, $n = 1018$, $p < .001$).

Table 5.1 Pearson Product-moment Correlation between Causal Beliefs, Attitudes, Preferred Treatment Pathways and Perceived Barriers to Help-seeking

		total score of psychosocial factors	total score of supernatural factors	total score of biological factors	total score of social distance	total score of traditional pathway	total score spiritual pathway	total score of orthodox pathway	total score of ideological barriers	total score of instrumental barriers
total score of psychosocial factors	Pearson Correlation Sig. (2-tailed) N	-	.176** .000 945	.536** .000 933	-.093** .005 909	.144** .000 942	-.046 .156 953	.161** .000 969	.058 .073 955	.038 .242 927
total score of supernatural factors	Pearson Correlation Sig. (2-tailed) N		-	.101** .001 993	.196** .000 970	.477** .000 1004	.563** .000 1019	-.106** .001 1030	.346** .000 1009	.233** .000 985
total score of biological factors	Pearson Correlation Sig. (2-tailed) N			-	-.082* .011 954	.084** .008 991	-.068* .032 1002	.104** .001 1026	.073* .021 1000	.038 .232 968
total score of social distance	Pearson Correlation Sig. (2-tailed) N				-	.120** .000 966	.186** .000 977	-.197** .000 995	.188** .000 974	.196** .000 947
total score of traditional pathway	Pearson Correlation Sig. (2-tailed) N					-	.625** .000 1023	-.082** .009 1038	.388** .000 1015	.411** .000 986
total score spiritual pathway	Pearson Correlation Sig. (2-tailed) N						-	-.100** .001 1050	.402** .000 1023	.338** .000 999
total score of orthodox pathway	Pearson Correlation Sig. (2-tailed) N							-	.026 .400 1046	-.134** .000 1018
total score of ideological barriers	Pearson Correlation Sig. (2-tailed) N								-	.405** .000 999
total score of instrumental barriers	Pearson Correlation Sig. (2-tailed) N									-

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

There was a weak positive relationship between the endorsement of supernatural causations and desire for social distance, $r = .20$, $n = 970$, $p < .001$. However, there was a negligible negative relationship between the endorsements of psychosocial ($r = -.09$, $n = 909$, $p < .01$) and biological ($r = -.08$, $n = 954$, $p < .05$) causations and desire for social distance. There was also a weak positive relationship between perceived ideological ($r = .19$, $n = 974$, $p < .001$) and instrumental ($r = .20$, $n = 947$, $p < .001$) barriers and desire for social distance. There was a weak positive relationship between the preference for the traditional ($r = .12$, $n = 966$, $p < .001$) and spiritual ($r = .12$, $n = 966$, $p < .001$) treatment pathways and desire for social distance, $r = .19$, $n = 977$, $p < .001$. However, there was a weak negative relationship between the preference for the conventional psychiatric treatment pathway and the desire for social distance, $r = -.20$, $n = 995$, $p < .001$.

There was a strong positive relationship between the endorsements of psychosocial and biological causations, $r = .54$, $n = 933$, $p < .001$. There was also a strong positive relationship between the preference for the traditional and spiritual treatment pathways, $r = .63$, $n = 1023$, $p < .001$. There was a weak positive relationship between the endorsement of supernatural causations and the endorsement of psychosocial ($r = .18$, $n = 945$, $p < .001$) and biological ($r = .11$, $n = 993$, $p < .01$) causations. However, there was a weak negative relationship between the preference for the conventional psychiatric treatment pathway and the preference for the spiritual treatment pathway, $r = -.10$, $n = 1050$, $p < .001$. There was a moderate positive relationship between perceived ideological and instrumental barriers, $r = .41$, $n = 999$, $p < .001$.

5.1.2 Summary of findings

Systematic associations among the variables could be observed from the foregoing with three emergent mental health models. There is the more prominent 'indigenous' model whereby supernatural causal belief positively correlates with preference for the spiritual (1a) and traditional treatment pathways (1b). There is also the 'scientific' model (2) with the biological and psychosocial causal beliefs positively correlating with preference for the conventional

psychiatric treatment pathway. Finally, there is the ‘complementary’ model (3) whereby psychosocial causal belief positively correlates with traditional treatment pathway.

5.2 Regression procedures

To furthermore clarify the mental health models, the preferred treatment pathways were regressed on the causal models to determine to what extent the former is predicted by the latter (see Table 5.2).

Table 5.2 Standard Multiple Regression of Causal beliefs as Predictors of Treatment Pathways

	Traditional pathway			Spiritual pathway			Conventional psychiatric pathway		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Constant	8.87	.98		8.20	.74		9.54	.42	
Psychosocial Causations	.06	.02	.09**	-.06	.02	-.12***	.03	.01	.14***
Supernatural Causations	.32	.02	.47***	.33	.02	.59***	-.05	.01	-.17***
Biological Causations	-.10	.04	-.01	-.05	.03	-.06	.03	.02	.06

Note * $p < .05$ ** $p < .01$ *** $p < .001$

The linear regression model was statistically significant in the prediction of preference for the traditional treatment pathway $F(3, 850) = 91.88$, $p < .001$, and accounted for 24.5% of the variance ($R^2 = .24$). Supernatural causal belief was the strongest predictor of preference for the traditional treatment pathway ($\beta = .47$, $t(853) = 15.68$, $p < .001$). Psychosocial causal belief was also a predictor of preference for the traditional treatment pathway ($\beta = .09$, $t(853) = 2.63$, $p < .01$). The model was also statistically significant in the prediction of the spiritual pathway $F(3, 859) = 152.61$, $p < .001$, and accounted for 34.8% of the variance ($R^2 = .35$). Supernatural causal belief was also the strongest predictor of the preference for the spiritual treatment pathway ($\beta = .59$, $t(862) = 21.26$, $p < .001$). On the other hand, psychosocial causal belief significantly predicted non-preference for the Spiritual Pathway ($\beta = -.12$, $t(862) = -3.59$, $p < .001$). The model was also statistically significant in the prediction of the conventional (psychiatric) treatment pathway $F(3, 876) = 15.73$, $p < .001$, and accounted for 5.1% of the variance ($R^2 = .05$). Psychosocial causal belief was the only significant predictor of the preference for the conventional psychiatric pathway ($\beta = .14$, $t(879) = 3.52$, $p < .001$). Conversely, supernatural causal belief predicted non-preference for the conventional

psychiatric pathway ($\beta = -.17$, $t(879) = -.5.13$, $p < .001$). Series of mediation analyses were furthermore conducted to investigate whether the desire for social distance and barriers to accessing mental healthcare mediate causal beliefs' prediction of preferred treatment pathways but none of these was significant (see appendix 1).

5.2.1. Summary of findings and preliminary discussion.

The regression procedure further streamlined the models; models 1a (Supernatural causal beliefs \rightarrow Traditional treatment pathway), 1b (Supernatural causal beliefs \rightarrow Spiritual treatment pathway), and 3 (Psychosocial causal belief \rightarrow traditional treatment pathway) were reinforced with the causal beliefs significantly predicting the respective treatment pathways. However, in model 2, only psychosocial causal belief significantly predicted preference for the conventional psychiatric treatment pathway, biological causal belief did not. The patterns of correlations shows that the constituent constructs of the scientific mental health model (psychosocial causal belief and conventional psychiatric treatment pathway) were negatively associated with desire for social distance and both perceived ideological and instrumental barriers to accessing mental healthcare. On the other hand, the constituent constructs of the indigenous mental health model (supernatural causal beliefs, spiritual and traditional treatment pathways) were all positively associated with desire for social distance and both perceived ideological and instrumental barriers to accessing mental healthcare. However, tests could not confirm mediation relationships between these variables.

5.3 Discussion

The strong positive relationship between the endorsement of supernatural causations and the preference for spiritual and traditional treatment pathways (the indigenous mental healthcare model) is to be expected. Theoretically, it is to be expected that remedy for conditions attributable to supernatural causes would be more appropriately sought through spiritual or traditional means. This is notwithstanding that situational variables such as

social desirability could interfere to bring discrepancy between belief and behaviour as observed in Chapter Three. As earlier noted, a common world-view in Nigeria as also framed in the hugely popular Nigerian home-video (Nollywood) is that mental illness is a phenomenon largely caused by supernatural and preternatural forces and most effectively remedied spiritually through faith or traditional interventions, or the syncretic application of the two (Atilola & Olayiwola, 2011). The positive relationship between the endorsement of supernatural causations and perceived ideological and instrumental barriers (to conventional treatment pathway) furthermore underscores the consideration that beliefs could impede seeking help through the conventional psychiatric treatment pathway. Such beliefs could discount the effectiveness of conventional psychiatric care (ideological barrier) and lead to poorer compliance with medication. This consideration is further directly supported by the negative relationship between the endorsement of supernatural causation and the preference for the conventional psychiatric treatment pathway and indirectly by the positive relationship between perceived ideological barriers and the preference for spiritual and traditional pathways in the sense that the more these barriers to conventional psychiatric care are perceived, the more the tendency to seek alternative care. On the other hand, the positive relationship between perceived instrumental barriers and the preference for the spiritual and traditional pathways underscore the earlier submission that poverty and poor mental health infrastructure that characterise the region additionally reinforce the patronage of alternative models of care to the extent that traditional and faith healers provide 70% of mental healthcare in the region (Adewuya & Makanjuola, 2009).

The association of the indigenous model with desire for social distance corroborates the observation that the more people hold supernatural causal views of mental illness, the more negative views and attitudes they have towards people with mental illness (cf. Chapter Two). Some supernatural causations such as effects of curses, nemesis, breaking of oath and mishandling of spiritual powers mostly reflect spiritual chastisement of a transgressor who

automatically incurs social distance because such victims are considered as deserving of their lot. Supernatural causations also include evil forces, occultism and spirit possession that suggest dangerousness and need for keeping a safe distance from a victim to avoid contamination or getting caught up in the fray. Yet, greater endorsement of supernatural causation could also reflect lacking in scientific (biopsychosocial) causal knowledge which has been shown to lead to deep-seated negative attitudes toward mental illness (Grausgruber et al., 2007; Putman, 2008; Ukpong & Abasiubong, 2010). Moreover, the model is associated with ideological barriers which include pessimism of prognosis and the myth of incurability which could highly stigmatise persons with mental illness. Studies demonstrate that increased treatability and recovery is highly associated with positive attitude towards mental illness (Naeem, Ayub, & Javid, 2006). Similarly, lacking access to effective mental healthcare (instrumental barriers) which is also associated with the indigenous model suggests the chronicity of mental illness which would likely prompt social distance. A study that examined attitudes toward people living with schizophrenia found that the public felt more positively towards people with schizophrenia who are in treatment than it felt about those that are not in treatment (NAMI as cited in Kobau et al., 2010).

The strong positive relationship between perceived ideological and instrumental barriers reflects a link between ideological and material poverty which corroborates the suggestion of the human capital theory (cf. Chapter Four) and the finding that ideological and instrumental determinants interact to inform help-seeking behaviour (Barker, Olukoya & Aggleton, 2005). A reverse influence is also possible in the sense that poverty (instrumental barrier) could directly inhibit access to education (ideological barrier) which limits the horizon of awareness. Considering the demographic correlates of the constituent constructs of the indigenous model, those with less education, the Protestants and the three occupational groups (students, teachers and the general public compared to the nurses) would more likely adopt this mental healthcare model compared to those with higher education, the Catholics and the nurses respectively. The

Nigeria-based respondents would also more likely adopt this model than the UK-based respondents.

The positive relationship between the endorsement of psychosocial causations and the preference for the conventional psychiatric treatment pathway (the scientific healthcare model) essentially suggests that advancing psychosocial causations could more likely encourage the utilisation of conventional psychiatric services in this sample. This is further supported by the finding that unlike supernatural attribution that was positively associated with both perceived ideological and instrumental barriers (to accessing conventional psychiatric care), there was no relationship between the endorsement of the biopsychosocial causal attributions and the perception of these barriers. The model is furthermore directly supported by there being no relationship between the perception of ideological barriers and the preference for the conventional psychiatric treatment pathway and the negative relationship between perceived instrumental barriers and the preference for conventional psychiatric treatment pathway. These demonstrate that those that adopt this scientific model of mental healthcare would not only be unlikely to be inhibited by debilitating beliefs from seeking conventional psychiatric care but would likely go for it so long as it is accessible. Unlike the indigenous model that is generally characterised by the desire for social distance, the constituent constructs of the scientific healthcare model (psychosocial causal beliefs and preference for the conventional psychiatric treatment pathway) are negatively associated with social distance. This demonstrates the likelihood that adopting this mental healthcare model in this context would more likely lessen than exacerbate desire for social distance in contrast to the indigenous model. This is particularly insightful given earlier indication that explanatory models interact with context to determine attitudinal outcomes (see Chapter Two). Based on the demographic correlates of the constituent constructs of the scientific healthcare model, those with high education, the Catholics and the nurses would more likely adopt this healthcare model compared to those with low education, the Protestants and the other occupational groups

(students, teachers and the general public compared to the nurses) respectively. The UK-based respondents would also more likely adopt this model than the Nigeria-based respondents.

The negative relationship between supernatural causal attribution and the conventional psychiatric treatment pathway is a critical finding with decisive implication for the prospect of achieving a complementary model of care or inculturating conventional psychiatric healthcare in the region. Disturbingly, it suggests a fundamental incompatibility between indigenous conceptualisations and conventional psychiatric healthcare. This is furthermore conversely underscored by the negative relationship between the endorsement of the biopsychosocial causal models and the preference for spiritual treatment pathway. These findings accentuate the need for education and research to continue to clarify indigenous conceptualisations and also facilitate dialogue between them and conventional psychiatry. On the other hand, they suggest how very formidable such important course of action could be hence the need for resilience and perseverance.

However, the data also provided some prospects for a complementary model of healthcare in the positive relationship found between the endorsements of psychosocial causations and the preference for the traditional treatment pathway. This suggests that scientific causal views could agree with (complement) traditional system of care. A key aspect of the traditional care system that could thus be enhanced is the social network which commands a very decisive influence in mental healthcare in this region. The significance of the social network in the region is underscored in the finding that 83.1% and 90.4% of the Nigeria and UK-based respondents respectively indicated that it is the most important factor in the life of someone with mental illness (more important than medication by implication). This is furthermore exemplified by the earlier submissions (cf. Chapter Three) that the social network, more than other factors, initiated help-seeking for persons with mental illness in this region. On the other hand, the risk of having a social network whose views could impede adequate mental

healthcare was also underscored in Chapter Four, where it was equally noted that social networks lack mental health literacy. These reinforce the significance of the prospect that the social network in this region could be receptive to enlightenment with the conventional psychosocial causal knowledge. That over 80% of the Nigeria-based respondents endorsed biological and psychosocial causations further corroborates that the social network would be receptive to enlightenment with the biopsychosocial causal models.

As psychosocial causal beliefs predict accessing of conventional psychiatric in this region, a social network enlightened on psychosocial causations would be more open to seeking healthcare for their suffering relatives from the conventional psychiatric facility or influence them to do so. This would also happen in the context of the social network still continuing to provide the traditional solidarity which appears to be lacking in the seemingly isolating conventional psychiatric system of care. Thus, a system built around a more enlightened social network holds key promise in mediating responsive mental healthcare in the region.

To empower the social network accordingly, the practice in developed health systems whereby relatives (social network) at greater risk of developing inheritable conditions are given priority attention (Dunn et al. 2013) could be adopted. For such psychotic condition as schizophrenia, those with family history of the illness who will likely form the immediate social network of a member in crises (Comer, 2015) need to be equipped, for instance, with the knowledge of the indicators of vulnerability, the stressor triggers, the antipsychotics and their demonstrable activities in the neural pathway. However, given how highly stigmatised mental illness is in the region, the pragmatics of the process must be determined with basic guarantee of utmost confidentiality. Relatives who would normally surround a sufferer admitted to a psychiatric facility in the region would be handy and pertinent population to begin with.

The non-significant mediation test results possibly suggest the strength of the direct effect; causal beliefs strongly predicting preferred treatment pathways even with controlled effects of ideological and instrumental barriers, and desire for social distance. Thus considered, altering causal beliefs alone could effectively re-shape help-seeking behaviour. However, there could also be important mediators which we were not able to test. This could be a task for future studies.

5.4 Summary of findings, Practical Implications and Recommendations

5.4.1 Chapter One

Significantly mixed endorsement of the supernatural, biological and psychosocial causal models was found in Chapter one and it represents a paradigm shift from the earlier predominance of supernatural causal explanations. However, supernatural causal attribution was still made significantly more than biological and psychosocial attributions. The leading endorsement of supernatural causations reflects the enduring traditional religious worldview of the people that shapes the conceptualisation of reality including psychopathology. While increased endorsements of the biopsychosocial models could be considered a reflection of improving mental health literacy based on the general advancement in scientific knowledge, an enabling background was found for these in the culture, the unitary vision of reality and the historical experiences of the people.

Mixed attribution reflects a holistic view of health and healing and provides empirical evidence against any assumption that the people in this region believe solely in the spiritual aetiologies of mental illnesses. Understanding the conceptualisation of illness is key to achieving therapeutic alliance which facilitates treatment adherence and satisfaction. Thus, healthcare professionals in this context must recognise the potential for patients to hold strongly mixed or even contradictory beliefs about their conditions. The finding of a positive relationship between the endorsement of supernatural causations and the endorsement of psychosocial and biological

causations strongly reinforces this. This challenges mental healthcare systems and therapists to demonstrate the skills necessary to respond effectively in this context especially as trivialising or pathologising clients' beliefs could work against therapeutic alliance. To be effective, therapists need to be culturally competent for only then could they appropriately demonstrate empathy and also be in the position to recognise when beliefs are indeed becoming pathological or inimical.

Demographic correlates of the explanatory models were identified for targeted interventions. For instance, those in non-nursing professions were significantly less likely to endorse the biopsychosocial causations compared to those in the nursing profession hence these would benefit from mental health education. Those with low education were significantly less likely to endorse psychosocial causations compared to those with higher education and would therefore benefit from enlightenment campaigns on psychosocial causations. That there was no significant difference in the pattern of the endorsement of the biological and psychosocial causations between the UK-based group and the Nigeria resident group demonstrates that acculturation could not significantly improve the biopsychosocial causal knowledge of the UK-based group. This suggests the need for formal system of mental health education for this group and related immigrant populations in the UK.

5.4.2 Chapter Two

Considerable negative attitudes were evident across the demographic groups which add to the refutation of earlier submissions that non-Western traditionalist societies appear immune to stigmatising attitudes towards people with mental illness. Negative attitudes constitute double jeopardy for the sufferer who already grapples with debilitating symptoms. At the heart of negative attitude in the region is the culture of shame and face saving. Deviancy (difference) associated with serious mental disorders is also a key trigger for negative attitudes in the conformist collectivist society. Moreover, the conceptualizations of mental illness in the region

including anecdotal beliefs, causal explanations, symptom representations, and labels adopted generally tend to promote stereotypes and negative attitudes. Pervasive negative attitude is a contradiction in the traditionally communitarian and predominantly Christian culture. More research is necessary to further unravel this contradiction especially given the significance of the traditional solidarity shown the vulnerable in this culture in compensating for the poor health facilities. Basic structures to combat stigma need to be in place including requisite legislative frameworks, mental health charities and advocacy for the rights of persons with mental illness.

Demographic groups that were relatively more identified with negative attitudes and that could therefore benefit from targeted interventions include: those that are not familiar with sufferers of mental illness, those in the older age bracket, the males, the Protestants, and the Nigeria-based respondents. Overall, however, the indispensability of education in improving attitudes was underscored in low education being associated with all the negative attitude constructs while higher education was associated relatively more with the positive attitude constructs. However, the supremacy of mental health education with experiential content in combating stigma is supported in nurses demonstrating significantly more of the positive and less of the negative attitude constructs than those in the non-nursing professions.

5.4.3 Chapter Three

Mixed treatment pathway preferences was found with more than half of the respondents endorsing each of the three treatment pathways; traditional, spiritual and conventional psychiatry. Contrary to expectation, the conventional psychiatric treatment pathway was preferred significantly more than the spiritual pathway which was in turn preferred significantly more than the traditional pathway. Consistent with the suggestion in Chapter One, this possibly reflects a paradigm shift from earlier traditional approaches to increasing scientific views

supposedly based on improved mental health literacy. However, possible discrepancy between attitude (preference for the conventional psychiatric pathway demonstrated in the survey) and subsequent behaviour (likely pathway to be taken when actually faced with mental health problem) was recognised especially given the contrary finding with clinical samples. Variables such as symptom severity, the bizarreness of some psychotic symptoms and the suddenness of their onset could lead to supernatural conceptualisations (reinforced by the religious worldview of the people) which could consequently lead to recourse to the spiritual and traditional pathways. Moreover, there is the possibility of responses being biased by social desirability effects especially given the socially backward view of the indigenous models compared to the conventional psychiatric model.

Mixed treatment preferences have important clinical implications; therapists need to recognise that in this context, clients' full loyalty to the therapeutic regimens they provide is not guaranteed. Therapists should not expect or presume that patients coming to the conventional psychiatric facility would rely exclusively on their services or be contented with treatment regimens that ignore their spiritual and cultural/traditional needs. The patient may syncretically patronise plurality of treatment models even while still undergoing conventional psychiatric therapy. There is also the possibility of switching treatment pathways at will. Such tendency would be reinforced by the rivalry that exists between different care pathways in this region which heightens the need for complementary relationship that supports cooperation between care providers with the prospect of cross-referral of patients. Indeed, the mixed treatment preferences found in the population theoretically provides an enabling disposition for the evolution of complementary and holistic model of care that would be responsive to the socio-cultural context with the strength of one pathway complementing the weakness of the others. This is an imperative especially given the inadequate conventional psychiatric care system, the need for culturally responsive services, and the indispensable place of alternative (faith and traditional) healers in the region. While the pragmatics of a complementary model must be

determined, establishing a formal system of chaplaincy services with trained chaplains that provide spiritual care in the conventional psychiatric system while recognising the medical needs of patients as obtained in developed health systems (VandeCreek & Burton, 2001) could be explored. Meanwhile, improving the cultural competence of professionals could be a starting point for a process that takes advantage of local opportunities to meet the mental health needs of the people in the region.

The mental healthcare preferences of demographic groups were also highlighted to inform the planning of services; those with low education would more likely opt for the traditional and spiritual treatment pathways compared to those with higher education while the reverse holds for the preference of conventional psychiatric treatment. Nurses would prefer conventional psychiatric treatment compared with those in the non-nursing professions while the reverse holds in the preference for the spiritual and traditional treatment pathways. The UK-based respondents would prefer conventional psychiatric treatment compared with the Nigeria-based respondents while the reverse holds in the preference for the traditional and spiritual healthcare pathways.

5.4.4 Chapter four

Ideological and instrumental barriers to help-seeking were significantly perceived. However, ideological barriers were perceived significantly more than instrumental barriers. This shows that determining the conceptualization of mental health could help in unravelling the reasons for the underutilization of mental health services in this region. Of more crucial implication for policy however is the likelihood that even with improved facilities and socio-economic status, services would likely be underused without greater improvement of mental health conceptualisations and adapting therapy to context. Mental health enlightenment campaigns therefore need to precede infrastructural interventions. Contextualising therapy for responsive outcome would include adopting more positive therapeutic approaches, for instance,

with less bureaucracy, more discreet services, and directing therapy to meet cultural expectations of outcome. Cultural competency in service delivery also demands that while the universals in mental health pathologies are promoted, healthcare providers need to be conversant with the cultural anthropology of the people whom they serve. This is deserving of priority place in the curriculum of trainee therapists.

To make for a responsive mental healthcare system, the study corroborates the call of the WHO (2008) for the integration of mental healthcare into the primary health care system. The study also highlighted demographic groups that would be more likely encumbered either ideologically or materially in accessing conventional psychiatric care hence constituting primary targets for educational and/or infrastructural interventions as applicable. The Nigeria based respondents would be more likely constrained both ideologically and instrumentally in accessing conventional psychiatric care compared with the UK based respondents. The non-nursing professions especially the students would also be more likely constrained both ideologically and instrumentally in accessing conventional psychiatric care compared with the nurses. Those with low education would also be more likely constrained materially in accessing conventional psychiatric care compared with those with higher education.

5.4.5 Chapter five

Systematic associations were found between causal beliefs and preferred treatment pathways resulting in three emergent mental health models: The first is the more pronounced ‘indigenous’ model whereby supernatural causal belief predicted preference for the spiritual and traditional treatment pathways. This model is associated with perceived ideological and instrumental barriers, and desire for social distance from persons with mental illness. Those with less education, the Protestants, the Nigeria-based respondents and the students, teachers and the general public (compared to the nurses) would more likely adopt this mental health model. This model suggests fundamental incompatibility between indigenous

conceptualisations and conventional psychiatric healthcare, and highlights the need for research to continue to engage with indigenous conceptualisations towards reaching greater understanding with conventional psychiatry. The second is the scientific model whereby psychosocial causal beliefs positively predicted preference for the conventional psychiatric treatment pathway. This model is negatively associated with perceived ideological and instrumental barriers, and desire for social distance from persons with mental illness. Those with high education, the Catholics and the nurses (compared with those in the non-nursing occupational groups) would more likely adopt this mental healthcare model. The third is the complementary model whereby psychosocial causal belief predicted preference for the traditional treatment pathway. The prospect of interface between the indigenous and the conventional psychiatric models was found in this complementary model. It suggests, for instance, that the social network (a key aspect of the traditional care system) could be receptive of enlightenment on psychosocial causations which predisposes for seeking conventional psychiatric care. Members of a social network could consequently seek conventional psychiatric care for themselves and for their suffering relatives or influence them to do so. Thus, while they help to get psychiatric care to be better received in this context, they would also continue to provide the highly regarded traditional solidarity in care that appear to be lacking in the seemingly isolating conventional care system.

5.5 Limitations of the study

Being an under-researched population, we adopted quantitative research method as ideal for generating more generalisable than subjective facts. On that note, the method also supported the selection of a large number of cases that helped best represent the target population. However, coming to the end of the study with some realisation of the complexity of mechanisms that inform behaviour in this society, we consider that measure of qualitative discourse could have further enriched the discussion of the findings. The study also adopted convenience sampling method as the most feasible option in the circumstances of the research

that involved periodic field trips to Nigeria. In that regard, the method was cost effective but it also introduced the possibility of selection bias resulting in the overrepresentation of some groups, for instance, those with higher education, the young and the Catholics. However, the imbalance fairly reflects the current demographic distribution in the region. Moreover, being a homogeneous culture, it was not envisaged that these factors would significantly undermine the findings. Most importantly, when the results of the exploratory studies that employed random sampling of survey areas were compared with the confirmatory study that employed convenience sampling, there was no significant difference.

There is also the possibility of response bias. Being a communitarian culture where solidarity is normative of the social value system, there is the general possibility of participants responding according to which behaviour is socially desirable especially faced with an undergraduate interviewer who represents Western education. Furthermore, the confirmatory study questionnaire that brought the four studies together was long hence the possibility of lowering response quality. An attempt was made to address this by predisposing potential respondents that the questionnaire could take up to 25 to 30 minutes to complete.

Although the study established the interrelationship of variables, given its non-experimental and cross-sectional nature, we are limited in our ability to make causal conclusions regarding the observed patterns. Furthermore, while the findings could be applicable beyond the target population to many comparable contexts in the sub-Saharan African region, they could not be generalised across Africa given the significant cultural variations. Multi-centred cross-ethnic study would be more pertinent to get a more reliable picture of the situation in the region. Moreover, though there was high response rate from the Nigeria-based sample (average of 97.9%), the 22.95% average response rate of the UK-based sample is relatively small and non-response can affect the generalisability of the findings.

Understandably, socio-economic concerns exacerbated by demands from home could constrain immigrant populations from sub-Saharan Africa from giving time to tasks such as completing of questionnaires that has no immediate material gratification. Yet, immigrant populations need to be made aware of the significance of their participating actively in such research that could inform policy to improve their lot as vulnerable minority groups. West African immigrants' low participation in mental health research has been noted (Thomas, 2008) and therefore needs investigating and addressing. While the stigma of mental illness could be a causal factor for this situation, research could possibly uncover methods that could work more effectively with these populations.

These limitations notwithstanding, some of the strengths of the study include that it explored an under-researched population and is community rather than professionally based which is significant for deinstitutionalisation policy. To our knowledge, it is the first study to simultaneously investigate the causal beliefs of mental illness, treatment preferences, attitudes towards people with mental illness, and perceived barriers to accessing formal mental healthcare in sub-Saharan Africa. It is also the first to compare the Nigeria and UK-based Igbo samples on these variables. The research process additionally developed standardised psychometric instruments that would provide clinicians with means for assessing social distance desired from persons with mental illness, treatment preferences and barriers to formal mental healthcare. The methodology that provided for initial exploratory before a subsequent confirmatory study on all the four dimensions of the study also helped to substantiate the findings.

5.6 Conclusion with proposed direction moving forward

This research underscores the complexity of life in traditional and borderline societies with the finding of how the Igbo society lives harmoniously with seeming contradictions that could be considered illogical from the perspective of Western psychology and psychiatry. This was evident across the four dimensions of mental illness investigated; in the mixed causal

attributions with biological, psychosocial and supernatural attributions being endorsed almost in equal measure (this was furthermore reinforced in the positive relationship between the three causal models); in the mixed preference of biomedical, spiritual and traditional healing methods; in the significant negative attitudes/desire for social distance from people with mental illness in a communitarian culture where solidarity is normative of the social value system. There was also the irony in the finding that ideological barriers were significantly perceived more than instrumental barriers in a region defined more by systemic and material poverty. These findings reflect the complexity of the worldview in this society whereby cultural conceptions of the mind remain more interwoven with a variety of religious and cultural beliefs as well as the ecological and social world. It underscores the decisive place of context in attending to experiences including psychopathologies.

To achieve therapeutic alliances and meet cultural expectations of outcome in this culture, care providers must therefore not insist on linear or 'logical' approach to interventions which could alienate sufferers. This becomes all the more important in the face of the disturbing globalisation of Western culture which presents just one version of human nature - one set of ideas about pain and suffering as being definitive. Adopting strictly Western approach in this cultural context could, for instance, strip away the local beliefs that provide buffers and safe harbour in the face of crises. It would be culturally inappropriate, for instance, to hurry to conclusive terminal diagnosis in this context because 'nothing is impossible for God'. An integrated healthcare model that is sensitive to the spiritual and cultural needs of the people is ideal. A major step moving forward from this study therefore is determining the pragmatics of such complementary care. While the universals in mental health pathologies are promoted, healthcare providers in this context and indeed all multi-cultural settings need to be conversant with the cultural anthropology of potential clients. This is deserving of priority place in the curriculum of trainee health professionals with a view to making them culturally competent so as to provide care that also meets cultural expectations of outcome.

A vital prospect for the evolution of complementary model of care in this context was realised in the finding of a positive relationship between holding psychosocial causal beliefs and taking the traditional pathway to care. Against this background, a promising step moving forward would be to enlighten the social networks of sufferers or people at risk accordingly with psychosocial causations since these constitute critical stakeholders in the traditional care pathway. Besides the prospects of such a campaign ultimately mediating greater acceptance of formal mental healthcare, it also holds some promise in curbing negative attitudes since belief in psychosocial causations was also associated with less desire for social distance.

This study also reveals the limitation of social conditioning in improving health beliefs as demonstrated in the finding of no difference between the Nigeria-based and the immigrant (UK-based) samples in the endorsement of biological and psychosocial causations. The improvement of the mental health literacy of immigrants and ethnic minority populations with regard to causal beliefs could therefore not be left to the dynamics of social change alone. They have specific need for mental health education. Another critical finding is the difference in help-seeking behaviour between clinical and non-clinical samples, with clinical samples, informed by symptom severity, being more pragmatic/realistic and responding more in accordance with socio-cultural norms. On the other hand, free from symptom effect, the non-clinical samples have the leisure of responding according to which behaviour is more socially desirable which, in this case, meant choosing the ‘Western’ biomedical treatment model. Evolving a process of disabusing people of the ‘colonial mentality’ that mostly inform social desirability bias is therefore a fundamental step in the evolution and acceptance of complementary model of care in this context.

This study also highlighted the determinant impact of mental illness conceptualisations in shaping attitude and help-seeking behaviour. The primacy of mental health education in improving mental illness conceptualisations was underscored in this regard. Carrying out

enlightenment campaigns beginning with groups at most risk including those with less education, the Protestants, those not familiar with persons with mental illness and the Nigeria-based respondents will therefore be a resourceful way of immediately giving back to this deprived society that generously responded to this research project. Finally, as perspectives including beliefs, attitudes and socio-economic situations change over time, periodic longitudinal studies would be necessary for the evolution of responsive model(s) of care at every era.

References

- Abasiubong, F. Obembe, A. & Ekpo, E. (2008). The opinion and attitude of mothers to mental retardation in Lagos, Nigeria. *Nigerian Journal of Psychiatry*, 6(2), 80-5.
- Abdullah, T. & Brown, T.L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review*, 31, 934–948.
- Abdulmalik, J.O. & Sale, S. (2012). Pathways to psychiatric care for children and adolescents at a tertiary facility in northern Nigeria. *Journal of Public Health in Africa*, 3, 15-17.
- Achebe, C. (2012). *There was a country: A personal history of Biafra*. London: Penguin Books
- Adams, M. (2003). The reflexive self and culture: a critique. *British Journal of Sociology*, 54(2), 221-238.
- Addis, M. E. & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, 58, 5-14.
- Adebowale, T.O. & Ogunlesi, A.O. (1999). Beliefs and Knowledge about aetiology of mental illness patients and their relatives. *African Journal of Med. Science*, 28, 35-41.
- Adeniyi, O. (2013, September 26). Yoruba, Igbo and Media Warriors. *ThisDay Newspaper*, Retrived from <http://www.thisdaylive.com/articles/yoruba-igbo-and-media-warriors/156884/>
- Adeosun, I. I., Adegbohun, A. A., Adewumi, T. A. & Jeje, O. O. (2013). The pathways to the first contact with mental health services among patients with schizophrenia in Lagos, Nigeria. *Schizophrenia Research and Treatment*. 769161.
- Adesomoju, A. (2013, June 14). Lagos: 21-Year-old arraigned for sleeping with mentally ill inmates. *Punch Newspaper*, Retrieved from <http://www.punchng.com/metro/21-year-old-arraigned-for-sleeping-with-mentally-ill-inmates/>
- Adewuya, A.O. (1993). A study of mental morbidity among primary care patients in Nigeria. *Comprehensive Psychiatry*, 34, 10-13.

- Adewuya, A. O. & Makanjuola, R.O. (2008). Lay beliefs regarding causes of mental illness in Nigeria: pattern and correlates. *Social Psychiatry and Psychiatric Epidemiology*, 43(4), 336-341.
- Adewuya A. O. & Makanjuola, R.O. (2009). Preferred Treatment for Mental illness Among Southwestern Nigeria. *Psychiatric Services*, 60(1), 121-124.
- Adewuya, A. O. & Oguntade, A. A. (2007). Doctors' attitude towards people with mental illness in Western Nigeria. *Social Psychiatry & Psychiatric Epidemiology*, 42, 931-936.
- Adewuya, A.O., Owoeye, A.O., Erinfolami, A.O. & Ola, B.A. (2011). Correlates of self-stigma among outpatients with mental illness in Lagos, Nigeria. *Int J Soc Psychiatry*, 57(4), 418-427.
- Adler, A. K. & Wahl, O. F. (1998). Children's beliefs about people labeled mentally ill. *American Journal of Orthopsychiatry*, 68, 321-326.
- Adler, L. L. & Mukherji, B. R. (1995). *Spirit versus scalpel: Traditional healing and modern psychotherapy*. Westport, CT: Bergin & Garvey.
- Afana, A., Dalgard, O., Bjertness, E., Grunfled, B. & El-Sarraj, E. (2000). The attitude of Palestinian primary Healthcare professionals in the Gaza strip towards mental illness. *Egyptian Journal of Psychiatry*, 23, 101-111.
- Afolayan, J.A. & Okpemuza, M. (2011). Sociocultural factors affecting mental health service delivery in neuropsychiatric hospital, Port Harcourt, Rivers State, Nigeria. *Continental Journal of Nursing Science* 3(1), 31- 40.
- Agbodike, C. (2008). *A centenary of catholic missionary activities in Ihiala 1908-2008*. Nkpor: Globe Communications.
- Aghukwa, N.C. (2009a) Attitude of health workers to the care of psychiatric patients. *Annals of General Psychiatry*, 8(19).
- Aghukwa, N.C. (2009b). Secondary school teachers' attitude to mental illness in Ogun state, Nigeria. *African Journal of Psychiatry*, 12(1), 59-63.
- Aghukwa, C. N. (2012). Care seeking and beliefs about the cause of mental illness among Nigerian psychiatric patients and their families. *Psychiatric Services*, 63(6).
- Ahmed, S., Adams, A., Chowdhury, M. & Bhuiya, A. (2000). Gender, socio-economic development and health-seeking behaviour in Bangladesh. *Social Science and Medicine* 51(3), 361-371.
- Aina, O.F. (2004). Mental illness and cultural issues in West African films: Implications for orthodox psychiatric practice. *Med. Humanities*, 30, 23-26.
- Ajzen, I. (1991). The theory of planned behaviour. *Organizational Behaviour and Human Decision Processes* 50, 179-211.
- Albarracin, D., Johnson, B.T., Fishbein, M. & Muellerleile, P.A. (2001). Theories of reasoned action and planned behavior as models of condom use: a meta-analysis. *Psychol Bull* 127(1):142-161.

- Al-Darmaki, F. R. (2003). Attitudes towards seeking professional psychological help: What really counts for United Arab Emirates University students? *Social Behavior and Personality*, 31(5), 497-508.
- Alegria, M., Robles, R., Freeman, D.H. et al. (1991). Patterns of mental health utilization among island Puerto Rican poor. *American Journal of Public Health* 81(7), 875-9.
- Alem, A. & Kebede, D. (2003). Conducting psychiatric research in the developing world: challenges and rewards. *British Journal of Psychiatry*, 182, 185-187.
- Alexander, L. A. & Link, B. G. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health*, 12(3), 271-289.
- Al-Issa, I. (2000). Does the Muslim religion make a difference in psychopathology? In I. Al-Issa (Ed.), *Al-Junun: Mental illness in the Islamic world*. Madison, CT: International Universities Press. pp. 277-293
- Al-Krenawi, A. & Graham, J.R. (1999). Gender and biochemical/traditional mental health utilization among the Bedouin-Arabs of the Negev. *Culture, Medicine and Psychiatry*, 23(2), 219-243.
- Al-Krenawi, A. & Graham, J.R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health & Social Work*, 25(1), 9-22.
- Al-Krenawi, A., Graham, J.R., Al-Bedah, E.A., Kadri, H.M. & Schwail, M.A. (2009). Cross-National Comparison of Middle Eastern University Students: Help-Seeking Behaviors, Attitudes toward Helping Professionals, and Cultural Beliefs about Mental Health Problems. *Community Mental Health Journal*, 45, 26-36.
- Al-Krenawi, A. & Graham, J.R. (2011). Mental health help-seeking among Arab university students in Israel, differentiated by religion. *Mental Health, Religion & Culture*, 14(2): 157-167
- Al-Rowaie, O.O. (2005). Predictors of attitudes toward seeking professional psychological help among Kuwait University Students. *PhD dissertation*, Virginia Polytechnic Institute and State University. Blacksburg, Virginia.
- Alqahtani, M. & Salmon, P. (2008). Cultural influences in the aetiological beliefs of Saudi Arabian primary care patients about their symptoms: the association of religious and psychological beliefs. *J Relig Health*, 47, 302-313.
- Alvidrez, J., Snowden, L.R., & Kaiser, D.M. (2008). The experience of stigma among black mental health consumers. *Journal of Health Care for the Poor and Underserved*, 19, 874-893.
- American Psychiatric Association (2005). *Diagnostic and Statistical Manual of Mental Disorders*. India: Jaypee Brothers Medical Publishers Ltd.
- American Psychiatric Association (2012, June 24). *People: African Americans*. Retrieved from <http://www.psychiatry.org/african-americans>
- Anderson, K.K., Fuhrer, R. & Malla, A.K. (2010). The pathways to mental health care of first-episode psychosis patients: a systematic review. *Psychological Medicine*, 40, 1585-1597.

- Andrade, L., Caraveo-Anduaga, J. J., Berglund, P., Bijl, R., Kessler, R. C., Demler, O., et al. (2000). Cross-national comparisons of the prevalences and correlates of mental disorders. *Bulletin of the World Health Organization*, 78, 413-425.
- Angel, R. & Thoits, P. (1987). The impact of culture on the cognitive structure of illness. *Cult Med Psychiatry*, 11, 465-494.
- Angermeyer, M.C., Buyantugs, L., Kenzine, D.V & Matschinger, H. (2004). Effects of labeling on public attitudes towards people with schizophrenia: are there cultural differences? *Acta Psychiatrica Scandinavica*, 109, 420–425.
- Angermeyer, M. C. & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatrica Scandinavica*, 113, 163-179.
- Angermeyer, M. C., Holzinger, A. & Matschinger, H. (2009). Mental health literacy and attitude towards people with mental illness: A trend analysis based on population surveys in the eastern part of Germany. *European Psychiatry*, 24, 225-232.
- Angermeyer, M.C. & Matschinger, H. (1996). Public attitude towards psychiatric treatment. *Acta Psychiatrica Scandinavica*, 94, 326-336.
- Angermeyer, M. C. & Matschinger, H. (1997). Social distance towards the mentally ill: results of representative surveys in the Federal Republic of Germany. *Psychological Medicine*, 27, 131-141.
- Angermeyer, M.C. & Matschinger, H. (1999). Social representations of mental illness among the public. In J. Guimon, W. Fisher & N. Sartorius (Eds.) *The Image of Madness*. pp. 20-28. Kassel: Karger.
- Angermeyer, M.C. & Matschinger, H. (2003). The stigma of mental disorder: effects of labelling on public attitudes towards people with mental disorder. *Acta Psychiatrica Scandinavica*, 108, 304-309.
- Angermeyer, M.C. & Matschinger, H. (2004). Public attitudes towards psychotropic drugs: have there been any changes in recent years? *Pharmacopsychiatry*, 37, 152-156.
- Angermeyer, M.C., & Matschinger, H. (2005). Causal Beliefs and attitudes to people with schizophrenia. *British Journal of Psychiatry*, 186, 331-334.
- Angermeyer, M. C., Matschinger, H. & Corrigan, P.W. (2004). Familiarity with mental illness and social distance from people with schizophrenia and major depression: testing a model using data from a representative population survey. *Schizophr Res.* 69(2-3), 175-82.
- Angermeyer, M.C., Matschinger, H. & Riedel-Heller, S.G. (2001). What to do about mental health disorder - help seeking recommendations of the lay public. *Acta Psychiatrica Scandinavica*, 103, 220-225.
- Angermeyer, M.C. & Schulze, B. (2001). Reinforcing stereotypes: how the focus on forensic cases in news reporting may influence public attitudes towards the mentally ill. *Int J Law Psychiatry*, 24, 469-486.

- Angermeyer, M. C., Schulze, B. & Dietrich, S. (2003). Courtesy stigma: A focus group study of relatives of schizophrenia patients. *Social Psychiatry and Psychiatric Epidemiology*, 38, 593-602.
- Aniebue, P. & Ekwueme, C. (2009). Health-seeking behaviour of mentally ill patients in Enugu, Nigeria. *South African Journal of Psychiatry*, 15(1), 19-22.
- Antonak, R. F. & Harth, R. (1994). Psychometric analysis and revision of the Mental Retardation Attitude Inventory. *Mental Retardation*, 32, 272-280.
- Appleby, L., Mortensen P.B. & Faragher, B.E. (1998). Suicide and other causes of mortality after post-partum psychiatric admission. *The British Journal of Psychiatry*, 173(9), 209-211.
- Appleby, L. & Wessely, S. (1988). Public attitudes to mental illness: the influence of the Hungerford massacre. *Medicine, Science and the Law*, 28, 291-295.
- Arboleda-Florez, J. (1998). Mental Illness and Violence: An Epidemiological Appraisal of the Evidence. *Can J Psychiatry*, 43, 989-996.
- Arboleda-Flórez, J. (2001). Stigmatization and Human Rights Violations. In *World Health Organization, Mental Health: A Call for Action by World Health Ministers*. Geneva: World Health Organization, pp. 57-70.
- Armitage, C.J. & Conner, M. (2001). Efficacy of the theory of planned behaviour: a meta-analytic review. *Br J Soc Psychol*, 40(4), 471-499.
- Arvaniti, A., Samakouri, M., Kalamara, E., Bochtsou, V., Bikos., C. & Livaditis, M. (2009). Health service staff's attitudes towards patients with mental illness. *Social Psychiatry & Psychiatric Epidemiology*, 44, 658-665.
- Asenso-Okyere, W., Anum, A., Osei-Akoto., I. & Adukonu, A. (1998). Cost Recovery in Ghana: are there any changes in health seeking behaviour? *Health Policy and Planning*, 13, 181-188.
- Asuni, T., Schoenberg, F., & Swift, C. (Eds.) (1994). *Mental health and disease in Africa*. Ibadan: Spectrum Books Ltd.
- Atilola, O. & Olayiwola, F. (2011). Mind Frames in Nollywood: Frames of Mental Illness in Nigerian Home Videos. *Research Journal of Medical Sciences*, 5(3), 166-171.
- Aubrey, R. (1991). International students on campus: A challenge for counselors, medical providers, and clinicians. *Smith College Students in Social Work*, 62, 20-33.
- Audu, I. A., Idris, S. H., Olisah, V. O., & Sheikh, T. L. (2013). Stigmatization of people with mental illness among inhabitants of a rural community in northern Nigeria. *International Journal of Social Psychiatry*, 59(1), 55-60.
- Australian Nurses Federation (2003). Survey reveals extent of violence toward nurses. *Australian Nursing Journal*, 11, 9.

- Awojobi, A. O. (2011). Rejuvenating Primary Health Care in Nigeria – The Ibarapa Experience. Paper presented at the symposium organized by the editorial board of DOKITA Paul Hendrickse Lecture Theatre, University College Hospital, Ibadan, Nigeria.
- Ay, P., Save, D. & Fidanoglu, O. (2006). Does stigma concerning mental disorders differ through medical education? A survey among medical students in Istanbul. *Soc Psychiatry Psychiatr Epidemiol*, 41, 63–67.
- Ayorinde, O., Gureje, O. & Lawal, R. (2004). Psychiatric research in Nigeria: bridging tradition and modernisation. *Br J Psychiatry*, 184, 536-538.
- Bag, B., Yilmaz, S. & Kirpinar, I. (2006). Factors influencing social distance from people with schizophrenia. *Int J Clin Pract*, 60, 289-294.
- Bailey, S. (1998). An exploration of critical care nurses' and doctors' attitudes toward psychiatric patients. *Australian Journal of Advanced Nursing*, 15(3), 8 - 14.
- Baker, G. A. (2002). The Psychosocial Burden of Epilepsy. *Epilepsia* 43(6), 26 - 30
- Bal, S. & Cochrane, R. (1993). Asian patients, somatisation and psychological distress: A cross-cultural comparison at the primary health care level. Unpublished Paper, University of Birmingham.
- Balhara, Y.P.S. & Yadav, T. (2012). A Comparative Study of Beliefs, Attitudes and Behaviour of Psychiatric Patients and their Care givers with Regards to Magico-religious and Supernatural Influences. *J. Med. Sci.*, 12(1), 10-17.
- Banerjee, G. & Roy, S. (1998). Determinants of help seeking behaviour of families of schizophrenic patients attending a teaching hospital in India: an indigenous explanatory model. *International Journal of Social Psychiatry*, 44, 199-214.
- Barcus, R. A. (1982). Mental health in Korea. *Clinical Psychologist*, 35(3), 16-19.
- Barimah, K. B. & Teijlingen, E.R.V. (2008). The use of traditional medicine by Ghanaians in Canada. *BMC Complementary and Alternative Medicine*, 8, 30.
- Barker, G., Olukoya, A. & Aggleton, P. (2005). Young people, social support and help-seeking. *International Journal of Adolescent Medicine and Health*. 17(4), 315-335.
- Barksdale, C.L. & Molock, S.D. (2008). Perceived norms and mental health help seeking among African American college students. *J Behav Health Serv Res*. 36(3), 285-99.
- Barney, L.J., Griffiths, K.M., Jorm, A.F. & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Aust N Z J Psychiatry*, 40(1), 51-54
- Baron, R. A. (1992). *Psychology*. Boston: Allyn & Bacon.
- Bartlett, M.S. (1954). A note on the multiplying factors for various chi square approximations. *Journal of the Royal Statistical Society*, 16, 296-8.
- Baruth, L. G. & Manning, M. L. (2003). Multicultural counseling and psychotherapy: A lifespan perspective. Upper Saddle River, NJ: Merrill Prentice Hall.

- Battaglia, J., Coverdale, J. H. & Bushong, C. P. (1990). Evaluation of a mental illness awareness week program in public schools. *American Journal of Psychiatry*, 147, 324–329.
- Bayer, J.K. & Peay, M.Y. (1997). Predicting intentions to seek help from professional mental health services. *Australian and New Zealand Journal of Psychiatry* 31, 504–513.
- Beach, M.C., Price, E.G., Gary, T.L., Robinson, K. A., Gozu, A., Palacio, A. & Cooper, L. A. (2005). Cultural competence: A systematic review of health care provider educational interventions. *Medical Care*, 43, 356–373.
- Bekele, Y.Y., Flisher, A.J., Alem, A., Bahiretebeb, Y. (2009). Pathways to psychiatric care in Ethiopia. *Psychological Medicine*, 39, 475-483.
- Bell, J.S., Aaltonen, S.E., Bronstein, E. et al. (2008). Attitudes of pharmacy students toward people with mental disorders, a six country study. *Pharm World Sci.* 30(5), 595-9.
- Benenson, J. F. & Koulkazarian, M. (2008). Sex differences in help-seeking appear in early childhood. *British Journal of Developmental Psychology*, 26(2), 163-170.
- Bergner, E., Leiner, A.S., Carter, T., Franz, L., Thompson, N.J. & Compton, M.T. (2008). The period of untreated psychosis before treatment initiation: a qualitative study of family members' perspectives. *Comprehensive Psychiatry* 49, 530–536.
- Berzins, K.M., Petch, A. & Atkinson, J.M. (2003). Prevalence and experience of harassment of people with mental health problems living in the community. *British Journal of Psychiatry*, 183, 526-533.
- Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2000). The challenge of cross-cultural healthcare-diversity, ethics, and the medical encounter. *Bioethics Forum*, 16(3).
- Betancourt, J.R. & Maina, A. (2007). *Barriers to eliminating disparities in Clinical Practice: Lessons from the 10M report "unequal treatment"*. Totowa, NJ: Humana Press.
- Bhana, A., Petersen, I., Baillie, K.L. & Flisher, A.J. (2010). The Mhapp Research Programme Consortium Implementing the World Health Report 2001 recommendations for integrating mental health into primary care: a situational analysis of three African countries Ghana, South Africa and Uganda. *Int Rev Psychiatry*, 22(6), 599-610.
- Bhugra, D. (2006). Severe mental disorder across cultures. *Acta Psychiatrica Scandinavica Supplementum*, 113(429), 17–23.
- Bhui, K., Bhugra, D., Goldberg, D., Dunn, G., & Desai, M. (2001). Cultural influences on the prevalence of common mental disorder, general practitioner's assessments and help-seeking among Punjabi and English people visiting their general practitioner. *Psychological Medicine*, 31, 815–825.
- Bhui, K., Bhugra, D. & Goldberg, D. (2002). Causal explanations of distress and general practitioners' assessments of common mental disorder among Punjabi and English attendees. *Social Psychiatry and Psychiatric Epidemiology*, 37, 38-45.

- Biddle, L., Gunnel, D., Sharp, D. et al. (2004). Factors influencing help seeking in mentally distressed young adults: a cross-sectional survey. *British Journal of General Practice*, 54(501), 248-53.
- Binitie, A. (1970). Attitude of educated Nigerians to mental illness. *Acta Psychiatrica Scandinavica*, 46, 27-46.
- Birkel, R.C. & Reppucci, N.D. (1983). Social networks, information-seeking, and the utilization of services. *Am J Community Psychol*. 11(2), 185-205.
- Björkman, T., Angelman, T. & Jonsson, M. (2008). Attitudes towards people with mental illness: a cross-sectional study among nursing staff in psychiatric and somatic care. *Scand J Caring Sci*, 22, 170-177.
- Black, K., Peters, L., Rui, Q. et al. (2001). Duration of untreated psychosis predicts treatment outcome in an early psychosis program. *Schizophrenia Research*, 47(2-3), 215-222.
- Boerner, H. (2009, February, 20). A new federal law intended to ensure equal access to mental healthcare falls short, doing little to help patients overcome the great obstacles they often face when seeking care. Journal of Patient advocacy. Retrieved from <http://nnumagazine.uberflip.com/i/198030-registered-nurse-october-2009/9>
- Bolman, W.M. (1968). Cross-cultural psychotherapy. *The American Journal of Psychiatry*, 124(9), 1237.
- Bonin, J.P., Fournier, L., & Blais, R. (2007). Predictors of mental health service utilization by people using resources for homeless people in Canada. *Psychiatric Services*, 58, 936-941.
- Bonner, G., Lowe, T., Rawcliffe, D. & Wellman, N. (2002). Trauma for all: a pilot study of the subjective experience of physical restraint for mental health in-patients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing*, 9, 465-473.
- Botha, U.A., Koen, L. & Niechaus, D.J.H. (2006). Perceptions of a South African Schizophrenia population with regards to community attitudes towards their illness. *Social Psychology and Psychiatric Epidemiology*, 41, 619-623.
- Bracken, P. J. (2001). Post-Modernity and Post-Traumatic Stress Disorder. *Social Science and Medicine*, 53(6), 733-743.
- Bradley, R. H. & Michael, H. (1987). Religious Affiliation, Attendance, and Support for "Pro-Family" Issues in the United States. *Social Forces*, 65(3), 858-882.
- Braff, D.L. (1992). Reply to cognitive therapy and schizophrenia. *Schizophrenia Bulletin*, 18(1), 37-38.
- British Psychological Society (1998). Briefing paper No.16: Services to Black and ethnic minority people, Leicester: Division of Clinical Psychology, British Psychological Society.
- Brockington, I.F., Hall, P., Levings, J. & Murray, C. (1993). The community's tolerance of the mentally ill. *British Journal of Psychiatry*, 162, 93-99.

- Broussard, B., Goulding, S.M., Talley, C.L. & Compton, M.T. (2010). Beliefs about causes of schizophrenia among urban African American community members. *Psychiatr. Q.*, 81, 349-362.
- Bruce, P. & Dohrenwend, B. P., (1966). Social Status and Psychological Disorder: An Issue of Substance and an Issue of Method, *American Sociological Review*, 31(1) 14-34
- Budman, C. L., Lipson, J. B. & Meleis, A. I. (1992). The cultural consultant in mental health care: The case of an Arab adolescent. *American Journal of Orthopsychiatry*, 62, 359-370.
- Burgess, P.M., Pirkis, J.E., Slade, T.N et al. (2009). Service use for mental health problems: findings from the 2007 National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry*, 43, 615–623.
- Burns, J.K., Ihazbhay, K. & Emsley, R. A. (2011). Causal attributions, pathway to care and clinical features of first-episode psychosis: A South African perspective. *Int J Soc Psychiatry*, 57(5), 538-545.
- Burton, V.S. (1990). The consequences of official labels: A research note on rights lost by the mentally ill, mentally incompetent, and convicted felons. *Community Mental Health Journal*, 26, 267-276
- Byrne, P. (1997). Psychiatric stigma: past, passing and to come. *Journal of the Royal Society of Medicine*, 90, 618 -620.
- Byrne, P. (1998). Fall and rise of the movie“psycho-killer”. *Psychiatric Bulletin*, 22, 174-176.
- Byrne P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment* 6, 65-72.
- Byrne, P. (2001). Psychiatric stigma. *British Journal of Psychiatry* 178, 281–284.
- Calhoun, E.A., Whitley, E.M., Esparza, A. et al. (2010). A national patient navigator training program. *Health Promotion Practice*, 11, 205–215.
- Cameron, L., Leventhal, E.A. & Leventhal, H. (1993). Symptom representations and affect as determinants of care seeking in a community-dwelling, adult sample population. *Health Psychology*, 12, 171-179.
- Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V. & Flisher, A.J. (2010). Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services. *Transcultural Psychiatry*, 47(4), 610-628.
- Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of health care services: A model of care. *Journal of Transcultural Nursing*, 13, 181-184.
- Canadian Alliance on Mental Illness and Mental Health (2000). A Call for Action: Building Consensus for a National Plan on Mental Illness and Mental Health.
- Canadian Mental Health Association (1994). Final report. Mental health anti-stigma campaign public education strategy. Toronto: Canadian Mental Health Association, Ontario Division.

- Carlson, R. & Shield, B. (1989). *Healers on healing*. Los Angeles: Tarchef.
- Carothers, J.C. (1948). A study of mental derangement in Africans, and an attempt to explain its peculiarities, more especially in relation to the African attitude to life. *Journal of Medical Science*, 93, 548-596.
- Carrillo, J.E., Green, A.R. & Betancourt, J.R. (1999). Cross-cultural primary care: a patient-based approach. *Ann Intern Med*. 130(10), 829-34.
- Carteret, M. (2011). Culturally based beliefs about illness causation. Dimensions of culture. Retrieved from <http://www.dimensionsofculture.com/2011/02/culturally-based-beliefs-about-illness-causation/2011/>
- Catell, R.B. (1966). The scree test for number of factors. *Multivariate Behavioural Research*, 1, 245-76.
- Cauce, A.M., Domenech-Rodriguez, M., Paradise, M. et al. (2002). Cultural and contextual influences in mental health help seeking: a focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, 70(1), 44-55.
- Central Intelligence Agency (CIA) (2012). Calculation from percentage and overall population count of Nigeria. The World Factbook. Langley, Virginia: CIA.
- Chadda, R K., Agarwal, V., Singh, M.C. & Raheja, D. (2001). Help seeking behaviour of psychiatric patients before seeking care at a mental hospital. *International Journal of Social Psychiatry*, 47(4), 471-478.
- Chandra, A. & Minkovitz, C.S. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of Adolescent Health*, 38(6), 754.e1-8.
- Chandra, A. & Minkovitz, C.S. (2007). Factors that influence mental health stigma among 8th grade adolescents. *Journal of Youth and Adolescence*, 36, 763-774.
- Chapman, D.P., Perry, G.S. & Strine, T.W. (2005). The vital link between chronic disease and depressive disorders. Preventing chronic disease. Retrieved February 19, 2015 from http://www.cdc.gov/pcd/issues/2005/jan/04_0066.htm
- Cheetham, R. W. S. & Rzadkowolski, A. (1980). Cross-cultural psychiatry and the concept of mental illness. *South African Medical Journal*, 58(8), 320-325.
- Chen, S. X., Benet-Martinez, V. & Bond, M.H. (2008). Bicultural identity, bilingualism, and psychological adjustment in multicultural societies: immigration-based and globalization-based acculturation. *Journal of Personality*, 76, 803-837.
- Cheng, H. L., Kwan, K. L. & Sevig, T. (2013). Racial and ethnic minority college students' stigma associated with seeking psychological help: Examining psychocultural correlates. *Journal of Counseling Psychology*, 60, 98-111.
- Chew-Graham, C., Bashir, C., Chantler, K., Burman, E., & Batsleer, J. (2002). South Asian women, psychological distress and self-harm: Lessons for primary care trusts. *Health and Social Care in the Community*, 10, 339-347.

- Chew-Graham, C.A., Rogers, A. & Yassin, N. (2003). 'I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. *Medical Education*, 37, 873-880
- Chou, K.L. & Mak, K.Y. (1998). Attitudes to mental patients among Hong Kong Chinese: a trend study over two years. *Int J Soc Psychiatry*, 44, 215-24.
- Ciarrochi, J. & Deane, F.P. (2001). Emotional competence and willingness to seek help from professional and nonprofessional sources. *British Journal of Guidance and Counselling*, 29, 233-246.
- Clark, L. & Hofsess, L. (1998). *Acculturation: Handbook of Immigrant Health*. New York: Plenum Press.
- Clarke, I. (2001). *Psychosis and spirituality*. London: Whurr.
- Cohen, P. & Hesselbart, C.S. (1993). "Demographic Factors in the Use of Children's Mental Health Services." *American Journal of Public Health*, 83(1), 49-52.
- Coker, E. M. (2005). Selfhood and social distance: toward a cultural understanding of psychiatric stigma in Egypt. *Social Science and Medicine*, 61, 920-930.
- Comer, R.J. (2015). *Abnormal Psychology*. London: Palgrave Macmillan.
- Compton, M.T., Esterberg, M. L., McGee, R., Kotwicki, R.J. & Olivia, J.R. (2006). Crisis intervention team training: Changes in knowledge, attitudes and stigma related to schizophrenia. *Psychiatric Services*, 57, 1199-1202.
- Compton, M.T., Kaslow, N.J., Walker, E.F. et al. (2004). Observations on parent/family factors that may influence the duration of untreated psychosis among African American first-episode schizophrenia-spectrum patients. *Schizophrenia Research* 68(2-3), 373-385.
- Conner, K. O., Copeland, V.C., Grote, N.K. et al. (2010). Mental health treatment seeking among older adults with depression: The impact of stigma and race. *American Journal of Geriatric Psychiatry*, 18, 531-543.
- Conner, K.O., Koeske, G. & Brown, C. (2009). Racial differences in attitudes toward professional mental health treatment: The mediating effect of stigma. *Journal of Gerontological Social Work*, 52, 695-712.
- Cooper, C.L. & Swanson, N. (2002). Workplace Violence in the Health Sector: State of the Art. National Institute of Occupational Safety and Health, Cincinnati, OH.
- Cooper, J. & Sartorius, N. (1977). Cultural and temporal variations in schizophrenia: A speculation on the importance of industrialization. *British Journal of Psychiatry*, 130, 50-55.
- Corrigan, P.W. (2004). How stigma interferes with mental health care. *American Psychologist*, 59, 614-625.
- Corrigan, P.W., Backs, A., Green, A., Lickey, S.E. & Penn, D.L. (2001). Prejudice, social distance, and familiarity with severe mental illness. *Schizophrenia Bulletin*, 27(2), 219-225.

- Corrigan, P.W., Druss, B.G. & Perlick, D. A. (2014). The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. *Psychological Science in the Public Interest*, 15(2), 37-70.
- Corrigan, P.W., Green, A., Lundin, R., Kubiak, M. A. & Penn, D. L. (2001). Familiarity with and social distance from people who have serious mental illness. *Psychiatric Services*, 52, 953-958.
- Corrigan, P.W., Lurie, B.D., Goldman, H.H., Slopen, N., Medasani, K. & Phelan, S. (2005). How adolescents perceive the stigma of mental illness and alcohol abuse. *Psychiatric Services*, 56(5), 544-550.
- Corrigan, P.W., Markowitz, F.E. & Watson, A.C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophr Bull.* 30(3), 481-491.
- Corrigan, P.W. & Miller, F. E. (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health*, 13, 537-548.
- Corrigan, P.W. & O'Shaughnessy, J.R. (2007). Changing mental illness stigma as it exists in the real world. *Aust Psychol*, 42, 90-97.
- Corrigan, P.W. & Penn, D. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, 54(9), 765-776.
- Corrigan, P.W., River, L.P., Lundin, R.K. et al. (2000). Stigmatising attributions about mental illness. *Journal of Community Psychology*, 28, 91-102.
- Corrigan, P.W., Rowan, D., Green, A. et al. (2002). Challenging two mental illness stigmas: personal responsibility and dangerousness. *Schizophr Bull*, 28, 293-309.
- Corrigan, P.W. & Watson, A.C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, 1, 16-20.
- Corrigan, P. & Watson, A. (2003). What factors influence how policy makers distribute resources to mental health services. *Psychiatric Services*, 54, 501-507.
- Corrigan, P.W., Watson, A.C., Warpinski, A.C. & Gracia, G. (2004). Stigmatizing attitudes about mental illness and allocation of resources to mental health services. *Community Ment Health J.* 40(4), 297-307.
- Corrigan, P. W., Watson, A.C., Warpinski, A.C. & Gracia, G. (2004). Implications of educating the public on mental illness, violence, and stigma. *Psychiatric Services*, 55, 577-580.
- Corrigan, P.W., Morris, S.B., Michaels, P.J., Rafacz, J. D. & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services*, 63, 963-973.
- Cotton, S, Wright, A., Harris, M.G., Jorm, A.F. & McGorry, P.D. (2006). Influence of gender on mental health literacy in young Australians. *Australian & New Zealand Journal of Psychiatry*, 40, 790-6.

- Couture, S.M., & Penn, D. L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health, 12*, 291-305.
- Courtenay, W.H. (2000). Engendering health: A social constructionist examination of men's health beliefs and behaviours. *Psychology of Men and Masculinity, 1*, 4-15.
- Cowan, S. (2003). NIMBY syndrome and public consultation policy: The implications of a discourse analysis of local responses to the establishment of a community mental health facility. *Health and Social Care in the Community, 11*(5), 379-386.
- Crabb, J., Stewart, R.C., Kokota, D. et al. (2012). Attitudes towards mental illness in Malawi: a cross-sectional survey. *BMC Public Health, 12*, 541.
- Craig, M. (2004). Perinatal risk factors for neonaticide and infant homicide: can we identify those at risk? *Journal of the Royal Society of Medicine, 97*(2), 57-61.
- Crawford, P. & Brown, B. (2002). 'Like a friend going round': reducing the stigma attached to mental healthcare in rural communities. *Health Soc Care Community, 10*(4), 229-38.
- Crisp, A.H., Gelder, M.G., Rix, S., Meltzer, H.I. & Rowlands, O, J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry, 177*, 4-7.
- Crozier, I. (2011). Making up koro: Multiplicity, psychiatry, culture, and penis-shrinking anxieties. *Journal of the History of Medicine and Allied Sciences, 67*, 36-70.
- Cunningham, P. J. & Freiman, M.P. (1996). "Determinants of Ambulatory Mental Health Services Use for School-Age Children and Adolescents." *Health Services Research, 31*(4), 409-27.
- Cusack, J., Deane, F., Wilson, C. et al. (2004). Who influence men to go to therapy? Reports from men attending psychological services. *International Journal for the Advancement of Counselling 26*(3), 271-283.
- Davidson, L., Rakfeldt, J. & Strauss, J.S. (2010). The roots of the recovery movement in psychiatry: Lessons learned. London, England: Wiley-Blackwell.
- Davis, L., Uezato, A., Newell, J. M. & Frazier, E. (2008). Major depression and comorbid substance use disorders. *Current Opinion in Psychiatry, 21*, 14-18.
- Deane, F.P., Skogstad, P. & Williams, M.W.M. (1999). Effects of attitudes, ethnicity and quality of prior therapy on male prisoners' intention to seek professional psychological help. *J Adv Couns, 21*, 55-67
- Dear, M.J. & Taylor, S.M. (1982). *Not on our street: community attitudes towards mental health care*. Londn: Pion Ltd.
- De Geyndt, W. (1995). *Managing the quality of health care in developing countries*. World Bank Technical Paper, no. 258.
- Dein, S. (2002). Transcultural Psychiatry (Letter). *British Journal of Psychiatry, 181*, 535-536

Demyttenaere K, Bruffaerts R, Posada-Villa, et al. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organisation World Mental Health Surveys. *Journal of the American Medical Association*, 291(21), 2581-2590.

Department of Health (2001). National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. London: HMSO.

Department of Health (2003). Attitudes to Mental Illness. London: DoH.

Department of Health (2005). Delivering race equality in mental health care: An action plan for reform inside and outside services and the government's response to the Independent inquiry into the death of David Bennett. London: DoH.

Deressa, W., Ali, A. & Enqusellassie, F. (2003). Self-treatment of malaria in rural communities, Butajira, southern Ethiopia. *Bulletin of the World Health Organization*, 81, 261-268.

Deribew, A. & Tamirat, Y. (2005). How are mental health problems perceived by a community in Agaro town? *Ethiop J Health*, 19, 153-159.

Dessoki, H.H. & Hifnawy, T.M.S. (2009). Beliefs about Mental Illness among University Students in Egypt. *Europe's Journal of Psychology* 5(1).

Dietrich, S., Beck, M. Bujantugs, B., Kenzine, D., Matschinger, H. & Angermeyer, M.C. (2004). The relationship between public causal beliefs and social distance toward mentally ill people. *Australian and New Zealand Journal of Psychiatry*, 38(5), 348-354.

Dietrich, S., Heider, D., Matschinger, H., Angermeyer, M.C. (2006). Influence of newspaper reporting on adolescents' attitudes toward people with mental illness. *Social Psychiatry and Psychiatric Epidemiology*, 41, 318-322.

Dinos, S., Stevens, S., Serfaty, M., Weich, S. & King, M. (2004). Stigma: the feelings and experiences of 46 people with mental illness. *Br J Psychiatry*, 184, 176-181.

Dixon, J.M. (2008). *Attitudes toward Acculturative Behavior Scale: Development, reliability and validity*. Unpublished doctoral dissertation, Ohio University.

Donati, F. (2000). *Madness and morale: A chronic psychiatric ward*. In R. Hinshelwood & W. Skogstad (Eds.). *Observing organisations*, (pp. 29-43). London: Routledge.

Donnelly, L.P. (2005). Mental health beliefs and help seeking behavior of Korean American parents of adult children with schizophrenia. *The Journal of Multicultural Nursing & Health*, 11, 23-34.

Donnelly, P. J. (1992). The impact of culture on psy-chotherapy: Korean clients' expectations in psy- chotherapy. *The Journal of New York State Nurses Association*, 23(2), 12-15.

Doornbos, M.M., Zandee, G.L., DeGroot, J. & De Maagd-Rodriguez, M. (2013). Using community-based participatory research to explore social determinants of women's mental health and barriers to help-seeking in three urban, ethnically diverse, impoverished, and underserved communities. *Arch Psychiatr Nurs*. 27(6), 278-84.

- DosReis, S., Mychailyszyn, M., Evans-Lacko, S. et al. (2009). The meaning of attention-deficit/hyperactivity disorder medication to parents' initiation and continuity of treatment for their child. *Journal of Child Adolescent Psychopharmacology*, 19(4), 377-383.
- Douglas, K.C. & Fujimoto, D. (1995). Asian Pacific elders: Implications for health care providers. *Clinical Geriatric Medicine*, 11, 69-82.
- Dovidio, J.F., Major, B. & Crocker, J. (2000). *Stigma: Introduction and overview*. In T. F. Heatherton, R. E. Kleck, M. R. Hebl & J. G. Hull (Eds.) *The social psychology of stigma*, (pp. 1-28). New York: Guilford.
- Dow, H. D. & Woolley, S. R. (2011). Mental health perceptions and coping strategies of Albanian immigrants and their families. *J Marital Fam Ther.* 37(1), 95-108.
- Drake, R. E., McHugo, G. J., Xie, H., Fox, M., Packard, J. & Helmstetter, B. (2006). Ten-year recovery outcomes for clients with co-occurring schizophrenia and substance use disorders. *Schizophrenia Bulletin*, 32, 464-473.
- Duckworth, K., Halpern, J.H., Schutt, R. K. & Gillespie, C. (2003). Use of schizophrenia as a metaphor in U.S. Newspapers. *Psychiatric Services*, 54, 1402-1404.
- Dunn, S. (1991). *Mind readings*. London: Mind.
- Dunn, K. E., Caleshu, C., Cirino, A. L., Ho, C. Y., & Ashley, E. A. (2013). A Clinical Approach to Inherited Hypertrophy: The use of family history in diagnosis, risk-assessment, and management. *Circulation. Cardiovascular Genetics*, 6(1), 118–131.
- Duxbury, J. (2002). An evaluation of staff and patient views of and strategies employed to manage inpatient aggression and violence on one mental health unit: a pluralistic design. *Journal of Psychiatric and Mental Health Nursing*, 9, 325-337.
- Earle, K.A. (1998). Cultural diversity and mental health: The Haudenosaunee of New York State. *Social Work Research*, 22, 89-99.
- Economou, M., Gramandani, C., Richardson, C. & Stefanis, C. (2005). Public attitudes towards people with schizophrenia in Greece. *World Psychiatry*, 4(1), 40-44.
- Edelman, C.L. & Mandle, C.L. (2002). *Health Promotion throughout the Life Span*. St Louis: Mosby.
- Edge, D. & MacKian, S.C. (2010). Ethnicity and mental health encounters in primary care: help-seeking and help-giving for perinatal depression among Black Caribbean women in the UK. *Ethnicity & Health* 15(1), 93-11.
- Edge, D. & Rogers, A. (2005). 'Dealing with it': Black Caribbean women's response to adversity and psychological distress associated with pregnancy, childbirth, and early motherhood. *Social Science and Medicine*, 61(1), 15-25.
- Edwards, S.P., Grobbelaar, P.W., Sibaya, P.T., Nene, L.M., Kunene, S.T. & Magwaza, A.S. (1983). Traditional Zulu Theories of Illness in Psychiatric Patients. *The Journal of Social Psychology*, 121, 213-221.

- Eisenberg, L. (1988). The social construction of mental illness. *Psychological Medicine*, 18(1).
- El-Islam, M.F. (2000). Mental illness in Kuwait and Qatar. In I. Al- Issa (Ed.), *Al-Junun: Mental illness in the Islamic world*, (pp.121-137). Madison, CT: International Universities Press.
- Elliot-Schmidt, R. & Strong, J. (1997). The concept of well-being in a rural setting: Understanding health and illness. *Aust J Rural Health*, 5, 59-63.
- Emejulu, J.K.C., Isiguzo, C.M., Agbasoga, C.E. & Ogbuagu, C.N. (2010). Traumatic Brain Injury in the Accident and Emergency Department of a Tertiary Hospital in Nigeria. *East and Central African Journal of Surgery*, 15(2), 28-38.
- Erickson, C.D. & Al Timimi, N.R. (2001). Providing mental health services to Arab Americans: Recommendations and considerations. *Cultural Diversity and Ethnic Minority Psychology*, 7, 308-327.
- Erinosho, O.A. & Ayorinde, A. (1978). A comparative study of opinion and knowledge about mental illness in different societies. *Psychiatry*, 4, 403-410.
- Eronen, M., Tihonen, J. & Hakola, P. (1996). Schizophrenia and homicidal behavior. *Schizophrenia Bulletin*, 22, 83-89.
- Essandoh, P.K. (1995). Counseling issues with African college students. *The Counseling Psychologist*, 23, 348-360.
- Esterberg, M.L. & Compton, M.T. (2006). Causes of schizophrenia reported by family members of urban African American hospitalized patients with schizophrenia. *Comprehensive Psychiatry*, 47, 221-226.
- Evans-Lacko S.E., Baum, N., Danis, M., Biddle, A. & Goold, S. (2012). Laypersons' choices and deliberations for mental health coverage. *Adm Policy Ment Health*. 39(3), 158-169.
- Ewhrudjakpor, C. (2009). Knowledge, Beliefs and Attitude of Health Care Providers towards the Mentally ill in Delta State, Nigeria. *Studies on Ethno-Medicine*, 3(1), 19-25.
- Ewhrudjakpor, C. (2010a). Psychiatric Institutions and the Emerging Institutional Scene in Nigeria. *African Research Review*, 4(1), 132-147.
- Ewhrudjakpor, C. (2010b). A comparative study of know ledge and attitude of urban and rural dwellers toward vagrant sufferers of schizophrenia in Delta State, Nigeria. *East African Journal of Public Health*, 7(2), 114-119.
- Fabiyi, O. (2013, October 15). Nigerians spend N250bn on medical tourism annually – Expert. The Punch News online. Retrieved from <http://odili.net/news/source/2013/oct/16/816.html>
- Fabrega, H. (1991). Psychiatric stigma in non-western societies. *Comprehensive Psychiatry*, 32, 534-551.
- Falk, G. (2001). *Stigma: How We Treat Outsiders*. New York: Prometheus Books.
- Fallot, R. (2001). Spirituality and religion in psychiatric rehabilitation. *International Review of Psychiatry*, 13, 110-116.

Farina, A. (1998). Stigma. In K.T. Mueser & N. Tarrier (Eds.), *Handbook of social functioning in schizophrenia*, (pp. 247-279). Boston: Allyn & Bacon.

Federal Ministry of Health (1991). *The National Mental Health Policy for Nigeria*. Abuja: Federal Ministry of Health

Federal Ministry of Health (1992). *The National Mental Health Policy for Nigeria*. Lagos: Federal Ministry of Health.

Feldman, D.B. & Crandall, C.S. (2007). Dimensions of mental illness stigma: What about mental illness causes social rejection? *Journal of Social and Clinical Psychology*, 26, 137-154.

Festinger, L. (1957). *A theory of cognitive dissonance*. California: Stanford University Press.

Fiske, S.T. & Taylor, S.E. (1991). *Social Cognition*. London: McGraw-Hill, Inc.

Flaskerud, J.H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Ment Health J*. 1986 Summer, 22(2), 127-41.

Foldemo, A., Gullberg, M., Ek, A.C. & Bogren, L. (2005). Quality of life and burden in parents of outpatients with schizophrenia. *Soc Psychiatry Psychiatr Epidemiol*. 40(2), 133-8.

Foskett, J., Marriott, J. & Wilson-Rudd, F. (2004). Mental health, religion and spirituality: Attitudes, experience and expertise among mental health professionals and religious leaders in Somerset, *Mental Health, Religion & Culture*, 7(1), 5-22.

Foster, R.P. (2001). When immigrant is trauma: Guideline for the individual and family clinician. *American Journal of Orthopsychiatry*, 71, 153-170.

Foucault, M. (1978) 'About the concept of the "dangerous individual" in 19th century legal psychiatry', *International Journal of Law and Psychiatry*, 1, 1-18.

Fox, J.C., Blank, M., Rovnyak, V.G. & Barnett, R.Y. (2001). Barriers to help seeking for mental disorders in a rural impoverished population. *Community Ment Health J*, 37(5), 421-436.

Francis, C., Pirkis, J., Dunt, D. & Blood, R.W. (2001). *Mental health and illness in the media: a review of the literature*. Canberra: Commonwealth Department of Health and Aged Care.

Freeman, M. (1992). Providing mental health care for all in South Africa - structure and strategy. Centre for the Study of Health Policy, Dept. of Community Health, Univ. of the Witwatersrand, Johannesburg.

Freeman, M. & Motsei, M. (1992). Planning health care in South Africa; is there a role for traditional healers? *Social Science & Medicine*. 35(11), 1183-1190.

French, S. (1996). The attitudes of health professionals towards disabled people. In G. Hales (Ed.), *Beyond disability: Towards an enabling society* (pp. 151-162). London: Sage Publications.

- Friedman, T., Newton, C., Coggan, C., et al. (2005). Predictors of A & E staff attitudes to self-harm patients who use self-laceration: influence of previous training and experience. *Journal of Psychosomatic Research*, 60, 273-277.
- Fujisawa, D., Hashimoto, N., Masamune-Koizumi, Y. et al. (2008). Pathway to psychiatric care in Japan: a multicenter observational study. *International Journal of Mental Health Systems*, 2, 14.
- Fuller, J., Edwards, J., Procter, N. et al. (2000). How definition of mental health problems can influence help seeking in rural and remote communities. *Australian Journal of Rural Health*, 8(3), 148-53.
- Fung, K. & Wong, Y.L. (2007). Factors influencing attitudes toward seeking professional help among East and Southeast Asian immigrant and refugee women. *International Journal of Social Psychiatry*, 53, 216-231.
- Furnham, A. (1997). Overcoming Neurosis. Lay attributions of cure for five specific disorders. *Journal of Clinical Psychology*, 53, 595-604.
- Furnham, A. & Chan, E. (2004). Lay theories of schizophrenia; a cross-cultural comparison of British and Hong Kong Chinese attitudes, attributions and beliefs. *Social Psychiatry and Psychiatric epidemiology*, 39, 543-552.
- Furnham, A. & Igboaka, A. (2007). Young People's Recognition and Understanding of Schizophrenia: a Cross-Cultural Study of Young People from Britain and Nigeria. *International Journal of Social Psychiatry*, 53(5), 430-446.
- Furnham, A. & Pereira, S. (2008). Beliefs about the cause, manifestation, and cure of schizophrenia: a cross-cultural comparison. *Mental Health, Religion and Culture*, 11(2), 173–191.
- Furnham, A., & Wong, L. (2007). A cross-cultural comparison of British and Chinese belief about the causes, behaviour, manifestations and treatment of schizophrenia. *Psychiatric Research*, 151 :123-38.
- Gabbard, G.O. & Gabbard, K. (1992). Cinematic stereotypes contributing to the stigmatization of psychiatrists. In P.J. Fink and A. Tasman (Eds.) *Stigma and Mental Illness*, (pp 113-126). Washington DC: American Psychiatric Press.
- Gaebel, W., Baumann, A., Witte, A. M. & Zaeske, H. (2002). Public attitudes towards people with mental illness in six German cities. *Eur Arch Psychiatry Clin Neurosci*, 252, 278-287.
- Gafoor, M. & Rassool, H.G. (1998). The coexistence of psychiatric disorders and substance misuse: working with dual diagnosis patients. *Journal of Advanced Nursing*, 27, 497-502.
- Gaines, A.D. (1998). Mental illness and immigration. In S. Loue (Ed.), *Handbook of immigrant health* (pp. 407-422). New York: Plenum.
- Gale, E. (2001). Promoting promotion. *Openmind*, 110, 14-15.

- Garfield, R.L., Zuvekas, S.H., Lave, J.R. & Donohue, J.M. (2011). The impact of national health care reform on adults with severe mental disorders. *American Journal of Psychiatry*, 168, 486-494.
- Gash, H. & Coffey, D. (1995). Influences on attitudes towards children with mental handicap. *European Journal of Special Needs Education*, 10, 1-16.
- Gater, R., Jordanova, V., Maric, N. et al. (2005). Pathways to psychiatric care in Eastern Europe. *Br J Psychiatry*, 186, 529-35.
- Gehlot, P.S. & Nathawat, S.S. (1983). Suicide and family constellation in India. *British Journal of Psychotherapy*, 37, 273-278.
- Geller, J.M. 1999. 'Rural Primary Care Providers' Perceptions of Their Roles in the Provision of Mental Health Services: Voices from the Plains.' *Journal of Rural Health*, 15(3), 326-34.
- Gellis, Z.D., Huh, N.S., Lee, S. & Kim, J. (2003). Mental health attitudes among Caucasian-American and Korean counseling students. *Community Ment Health J.* 39(3), 213-24.
- Gerace, L.M., Hughes, T.L. & Spunt, J. (1995). Improving nurses' responses toward substance-misusing patients: a clinical evaluation project. *Archives of Psychiatric Nursing*, 9, 286-294.
- Gilbert, P., Gilbert, J. & Sanghera, J. (2004). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health service use in South Asian Women living in Derby. *Mental Health, Religion and Culture*, 7, 109-130.
- Gilbert, P., Bhundia, R., Mitra, R., McEwan, K., Irons, C. & Sanghera, J. (2007). Cultural differences in shame-focused attitudes towards mental health problems in Asian and Non-Asian student women. *Mental Health, Religion & Culture*, 10(2), 127-141.
- Gillborn, D. & Gibbs, C. (1996). Recent research on the achievement of ethnic minority pupils. London: HMSO.
- Goetz, E.R., Camargo, B.V., Bertoldo, R.B. & Justo, A.M. (2008). Representação social do corpo na mídia impressa. *Psicologia e Sociedade*, 20(2), 226-236.
- Goffman, E. (1967). *Interaction Rituals: Essays in Face-to-Face Behaviour*. Chicago, IL: Aldine.
- Good, G. E. & Wood, K. (1995). Male gender role conflict, depression, and help seeking: Do college men face double jeopardy? *Journal of Counseling & Development*, 74, 70-75.
- Goode, E. (2000). *Paranormal beliefs: A Sociological Introduction*. Illinois: Waveland Press.
- Goodman, D. (1992). Link of violent crime to mentally illness dispelled by researcher. *Public Health Reports*, 107(1), 126-128.
- Gournay, K. (1996). Double bind. *Nursing Times*, 92, 28-29.

- Graham, N., Lindesay, J., Katona, C. et al. (2003). Reducing stigma and discrimination against older people with mental disorders: A technical consensus statement. *International Journal of Geriatric Psychiatry*, 18, 670-678.
- Granerud, A. & Severinsson, E. (2006). The struggle for social integration in the community - the experiences of people with mental health problems. *Journal of Psychiatric and Mental Health Nursing*, 13(3), 288-293.
- Grausgruber, A., Meise, U., Katschnig, H., Schöny, W. & Fleischhacker, W.W. (2007). Patterns of social distance towards people suffering from schizophrenia in Austria: A comparison between the general public, relatives and mental health staff. *Acta Psychiatrica Scandinavica*, 115(4), 310-319.
- Gray, A.J. (2001). Attitudes of the public to mental health: A church congregation. *Mental Health, Religion & Culture*, 4(1), 71-79.
- Greene-Shorridge, T. M., Britt, T. W. & Castro, C. A. (2007). The stigma of mental health problems in the military. *Military Medicine*, 172(2), 157-161.
- Green, G., Hayes, C., Dickinson, D., Whitaker, A. & Gilheaney, B. (2003). A mental health service users perspective to stigmatisation. *Journal of Mental Health*, 12, 223-234.
- Green, M.M. 1947. Ibo Village Affairs. London: Sidwick and Jackson.
- Griffiths, K.M., Nakane, Y., Christensen, H., Yoshioka, K., Jorm, A. F. & Nakane, H. (2006). Stigma in response to mental disorders: a comparison of Australia and Japan. *BMC Psychiatry*, 6, 21.
- Griffiths, R. & Pearson, B. (1988). *Working with Drug Users*. Hampshire: Wildwood House.
- Grunitzky, E.K., Balogou, A.A.K. & Dodzro, C.K. (2000). Clinical and epidemiological aspects of traditional therapeutic scarifications of epileptics in Togo. *Bulletin de la Société de Pathologie Exotique*, 93, 251-254
- Guerra, N. G. & Jagers, R. (1998). The importance of culture in the assessment of children and youth. In V. C. McLoyd & L. Steinberg (Eds.), *Studying minority adolescents: Conceptual, methodological, and theoretical issues* (pp. 123-142). Mahwah, NJ: Erlbaum.
- Gulbinat, W., Manderscheid, R., Baingana, F. et al. (2004). The International Consortium on Mental Health Policy and Services: objectives, design and project implementation. *Int Rev Psychiatry*. 16(1-2), 5-17.
- Gulliver, A., Griffiths, K.M. & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry*, 10, 113.
- Güleç, H., Yavuz, A., Topbaş, M., Ak, İ. & Kaygusuz, E. (2006). Psikiyatri hastalarında tıp dışı çare arama davranışı: Türkiye'de ve Almanya'da yaşayan Türkler arasında karşılaştırmalı bir ön çalışma. *Klinik Psikiyatri*, 9, 36-44.
- Güner-Küçükkaya, P & Ünal, S. (2012). Help-Seeking Behaviors of Turkish Patients Prior to Accessing a Psychiatric Polyclinic. *Archives of Psychiatric Nursing*, 26(2), 145-154.

- Gureje, O. (2003). Country Profile: Psychiatry in Nigeria. *Inter Psychiatry*, 2, 10-12.
- Gureje, O. (2007) Psychiatry in Africa: the myths, the exotic, and the realities. *South African Psychiatric Review*, 10, 11-14.
- Gureje, O., Abdulmalik, J., Kola, L., Musa, E., Yasamy, M.T. & Adebayo, K. (2015). Integrating mental health into primary care in Nigeria: report of a demonstration project using the mental health gap action programme intervention guide. *BMC Health Services Research*, 15, 242.
- Gureje, O. & Alem, A. (2000). Mental Health Policy Development in Africa. *Bull World Health Organ*. 78(4), 475-482.
- Gureje, O. & Bamidele, R. (1999). Thirteen-year social outcome among Nigerian outpatients with schizophrenia. *Soc Psychiatry Psychiatr Epidemiol*. 34(3), 147-51.
- Gureje, O., Chisolm, D., Kola, L., Lasebikan, V. & Saxena, S. (2007). Cost effectiveness of an essential mental health intervention package in Nigeria. *World Psychiatry*, 6(1), 42-48.
- Gureje, O. & Lasebikan, V.O. (2006). Use of Mental Health Services in a Developing Country: Results from the Nigerian Survey of Mental Health and Well-being. *Soc Psychiatry Psychiatr Epidemiol.*, 41(1), 44-9.
- Gureje, O, Olley, O. O., Ephraim-Oluwanuga, O. & Kola, L. (2006). Do beliefs about causation influence attitudes to mental illness. *World Psychiatry*, 5, 104-107.
- Gureje, O., Lasebikan, V.O., Ephraim-Oluwanuga, O., Olley, B. O. & Kola, L. (2005). Community study of knowledge of and attitude to mental illness in Nigeria. *British Journal of Psychiatry*, 186, 436-441.
- Gutierrez-Lobos, K. (2002). Rechtliche Benachteiligung psychisch Kranker in bsterreich. (Legal discrimination of mentally disordered persons in Austria). *J Neuropsychiatrie*, 16, 22-26.
- Hagemaster, J., Handley, S., Plumlee, A., Sullivan, E. & Stanley, S. (1993). Developing educational programmes for nurses that meet today's addiction challenges. *Nurse Education Today*, 13, 421-425.
- Hagger, M.S., Chatzisarantis, N.L., Barkoukis. V. et al. (2007). Cross-cultural generalizability of the theory of planned behavior among young people in a physical activity context. *J Sport Exerc Psychol* 29(1), 1-20.
- Haghighat, R. (2001). A unitary theory of stigmatisation: pursuit of self interest and routes to destigmatisation. *Br J Psychiatry*, 178, 207-215.
- Haines, M.M., McMunn, A., Nazroo, J.Y. & Kelly, Y.J. (2002). "Social and Demographic Predictors of Parental Consultation for Child Psychological Difficulties." *Journal of Public Health and Medicine*, 24, 276-84.
- Hall, L., & Tucker. C. (1985). Relationships between ethnicity, conceptions of mental illness, and attitudes associated with seeking psychological help. *Psychological Reports*, 57, 907-916.

- Hamid, P.D., Simmonds, J.G. & Bowles, T.V. (2009). Asian Australian acculturation and attitudes toward seeking professional psychological help. *Australian Journal of psychology*, 61, 69-76.
- Harrison, G., Hopper, K., Craig, T. et al. (2001). Recovery from psychotic illness: a 15- and 25-year international follow-up study. *Br J Psychiatry*, 178, 506-17.
- Harrison, M., Koenig, H., Hays, J., Eme-Akwari, A. & Pargament, K. (2001). The epidemiology of religious coping: a review of recent literature. *International Review of Psychiatry*, 13, 86-93.
- Hartley, D., Korsea, N., Bird, D. & Agger, M. (1998). Management of patients with depression by rural primary care practitioners. *Arch Fam Med*, 7, 139-145.
- Haustein, J. (2011). 'Embodying the Spirit(s): Pentecostal Demonology and Deliverance Discourse in Ethiopia.' *Ethnos*, 76(4), 534-552.
- Hawton, K., Daniels, R. & James R. (1995). General Hospital services for attempted suicide patients: a survey in one Region. *Health Trends*, 27, 18-21.
- Haynes, J.M. (2007). Video Boom: Nigeria and Ghana. *Postcolonial Text*, 3, 1-10.
- Heider, F. (1958). *The Psychology of Interpersonal Relations*. New York: Wiley.
- Hemmens, C., Miller, M., Burton, V.S. & Milner, S. (2002). The consequences of official labels: An examination of the rights lost by the mentally ill and mentally incompetent ten years later. *Community Mental Health*, 38, 129-140.
- Henderson, C., Corker, E., Lewis-Holmes, E. et al. (2012). Reducing mental health related stigma and discrimination in England: one year outcomes of the Time to Change Programme for service user-rated experiences of discrimination. *Psychiatr Serv*. 63(5), 451-457.
- Henderson, C., Evans-Lacko, S. & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American Journal of Public Health*, 103(5), 777-80.
- Hitchens, D. (2015). The remarkable case of Mr B. *The Catholic Herald*, 6732.
- Higgins, A. & Conner, M. (2003). Understanding adolescent smoking: the role of the theory of planned behavior and implementation intentions. *Psychol Health Med* 8(2), 173-186.
- Hines-Martin, V., Brown-Piper, A., Kim, S. et al. (2003). Enabling factors of mental health service use among African Americans. *Archives of Psychiatric Nursing*, 17(5), 197-204.
- Hinshaw, S. P., & Stier, A. (2008). Stigma as related to mental disorders. *Annu Rev Clin Psychol* 4, 367-393.
- Ho, E., Au, S., Bedford, C. et al. (2002). *Mental Issues for Asians in New Zealand: A Literature Review*. Wellington: Mental Health Commission.
- Hochbaum, G.M. (1958). Public Participation in Medical Screening Programs: A socio-psychological Study. *Public Health Service Publication*, 572.

- Högberg, T., Magnusson, A., Ewertzon, M. & Lützén, K. (2008). Attitudes towards mental illness in Sweden: Adaptation and development of the Community Attitudes towards Mental Illness questionnaire. *International Journal of Mental Health Nursing*, 17, 302-310.
- Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I. & Koffman, R.L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351(1), 13-22.
- Hopper, K. & Wanderling, J. (2000). Revisiting the developed versus developing country distinction in course and outcome in schizophrenia: results from ISOs, the WHO collaborative follow-up project. International study of schizophrenia. *Schizophr Bull.*, 26(4), 835-46.
- Hough, R.L., Willging, C.E., Altschul, D. & Adelsheim, S. (2011). Workforce capacity for reducing rural disparities in public mental health services for adults with severe mental illness. *Rural Mental Health*, 35(2), 35-45.
- Howerton, A., Byng, R., Campbell, J., Hess, D., Owens, C. & Aitken, P. (2007). Understanding help-seeking behaviour among male offenders: qualitative interview study. *British Medical Journal*, 334(7588), 303.
- Hsu, G. (2003). Priorities for Asian American Mental Health. Paper presented at the Conference of the NY Coalition for Asian American Mental Health on Beyond Cultural Competence: Challenges and opportunities for Asian American Mental Health, New York.
- Hugo, M. (2001). Mental health professionals' attitudes towards people who have experienced a mental health disorder. *Journal of Psychiatric Mental Health Nursing*, 8(5), 419-25.
- Hugo, C.J., Boshoff, D.E., Traut, A. Zungu-Dirwayi, N. & Stein, D.J. (2003). Community attitudes toward and knowledge of mental illness in South Africa. *Social Psychiatry and Psychiatry Epidemiology*, 38, 715-719.
- Hunter, M.S., Grunfeld, E.A. & Ramirez, A.J. (2003). Help-seeking intentions for breast-cancer symptoms: a comparison of the self-regulation model and the theory of planned behaviour. *Br J Health Psychol*, 8(3), 319-333.
- Hunter, L.R. & Schmidt, N.B. (2010). Anxiety psychopathology in African American adults: literature review and development of an empirically informed sociocultural model. *Psychol Bull.* 136(2), 211-35.
- Huxley, P. (1993). Location and stigma: a survey of community attitudes to mental illness. *Journal of Mental Health*, 2, 73-80.
- Hwang, W.C., Myers, H.F., Abe-Kun, J. & Ting, J.Y. (2008). A Conceptual Paradigm for understanding culture's impact on mental health: the cultural influences on mental health (CIMH) model. *Clinical Psychology Review*, 28(2), 211-227.
- Idemudia, E.S. (2004). 'Mental Health and Psychotherapy through the eyes of culture: Lessons for African Psychotherapy'. In H.Arlt and E.S. Idemudia E.S. (eds.), *The Unifying Aspects of Cultures*, (pp. 230-232), Vienna, Austria.

- Igbinomwanhia, N.G., James, B.O. & Omoaregba, J.O. (2013). The attitudes of clergy in Benin City, Nigeria towards persons with mental illness. *African Journal of Psychiatry*, 16, 196-200.
- Ikwuka, U., Galbraith, N. & Nyatanga, L. (2014). Causal attribution of mental illness in south-eastern Nigeria. *International Journal of Social Psychiatry*, 60(3), 274-9.
- Ikwuka, U., Galbraith, N., Manktelow, K., Chen-Wilson, J., Oyeboode, F & Muomah, R.C. (2016a). Attitude towards mental illness in southeastern Nigeria: the contradictions of a communitarian culture. *Journal of Community Psychology*, 44(2), 182-198.
- Ikwuka, U., Galbraith, N., Manktelow, K., Chen-Wilson, J., Oyeboode, F., Muomah, R.C. & Igboaka, A. (2016b). Ideological vs. Instrumental Barriers to Accessing Formal Mental Health care in the Developing World: Focus on South-eastern Nigeria. *Journal of Health Care for the Poor and Underserved*, 27(1): 157-175.
- Ikwuka, U., Galbraith, N., Manktelow, K., Chen-Wilson, J., Oyeboode, F., Muomah, R.C. & Igboaka, A. (in press). Pathways to Mental Healthcare in south-eastern Nigeria: manning the crossroads. *Transcultural Psychiatry*.
- Ilechukwu, S.T. (1988). Inter-relationships of beliefs about mental illness, psychiatric diagnosis and mental health care delivery among Africans. *International Journal of Social Psychiatry*, 34, 200-6.
- Iliyasu, M. & Last, M. (1991). Mental illness at Goron Dutse Psychiatric hospital. *Kano Studies*, 3, 41-70.
- International Labour Organization (2003). Preventing Discrimination, Exploitation and Abuse of Women Migrant Workers: An Information Guide - Booklet 1: Why the Focus on Women International Migrant Workers. Geneva: International Labour Organization.
- Issa, B.A., Parakoyi, D.B., Yussuf, A.D. & Musa, I.O. (2008). Caregivers' Knowledge of Etiology of Mental Illness in a Tertiary Health Institution in Nigeria. *Iranian Journal of Psychiatry and Behavioral Sciences (IJPBS)*, 2(1), 43-49.
- Jack-Ide, I.O. & Uys, L. (2013). Barriers to mental health services utilization in the Niger Delta region of Nigeria: service users' perspectives. *Pan African Medical Journal*, 14, 159.
- Jack-Ide, I.O., Uys, L. & Middleton, L.E. (2013). Caregiving experiences of families of persons with serious mental health problems in the Niger Delta region of Nigeria. *Int J Ment Health Nurs* 22(2), 170-9.
- Jacobsson, L. & Merdasa, F. (1991). Traditional perceptions and treatment of mental disorders in western Ethiopia before the 1974 revolution. *Acta Psychiatr Scand.*, 84(5): 475-81.
- Jagdeo, A., Cox, B.J., Stein, M.B. & Sareen, J. (2009). Negative attitudes toward help seeking for mental illness in 2 population-based surveys from the United States and Canada. *Can J Psychiatry*, 54(11), 757-66
- Jang, Y., Kim, G., Hansen, L. & Chiriboga, D.L. (2007) Attitudes of older Korean Americans toward mental health services. *Journal of American Geriatrics Society*, 55(4), 616-620.
- Jelen, T.G. (1984). "Respect for Life, Sexual Morality, and Opposition to Abortion." *Review of*

Religious Research, 25, 220-31.

Jenkins, J.H. & Karno, M. (1992). The Meaning of Expressed Emotion: Theoretical Issues Raised by Cross-Cultural Research. *Am J Psychiatry*, 149(1).

Johannessen, J.O., McGlashan, T.H., Larsen, T.K. et al. (2001). Early detection strategies for untreated first-episode psychosis. *Schizophrenia Research* 51(1), 39-46.

Jones, E.E., Farina, A. Hastorf, A.H., Marcus, H., Miller, D.T. & Scott, R.A. (1984). *Social Stigma: The Psychology of Marked Relationships*. New York: Freeman and Company.

Jorm, A.F. (2000). Mental health literacy: public knowledge and beliefs about mental disorders. *Br J Psychiatry*, 177, 396-401.

Jorm, A.F. (2012). Mental Health Literacy: Empowering the Community to Take Action for Better Mental Health. *American Psychologist*, 67(3), 231-43.

Jorm, A.F., Christensen, H. & Griffiths, K.M. (2005). The impact of beyondblue: The national depression initiative on the Australian public's recognition of depression and beliefs about treatments. *Australian & New Zealand Journal of Psychiatry*, 39, 248-254.

Jorm, A.F., Christensen, H. & Griffiths, K. M. (2006). The public's ability to recognize mental disorders and their beliefs about treatment: Changes in Australia over 8 years. *Australian & New Zealand Journal of Psychiatry*, 40, 36-41.

Jorm, A.F. & Griffiths, K.M. (2008). The public's stigmatizing attitudes towards people with mental disorders: how important are biomedical conceptualizations? *Acta Psychiatrica Scandinavica*, 118(4), 315-21.

Jorm, A.F., Korten, A.E., Jacomb, P.A., Christensen, H., Rodgers, B. & Pollitt, P. (1997). "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, 166, 182-186.

Jorm, A.F., Korten, A.E., Jacomb, P.A. et al. (1997). Helpfulness of interventions for mental disorders: beliefs of health professionals compared with the general public. *Br J Psychiatry* 171, 233-237.

Jorm, A.F., Nakane, Y., Christensen, H., Yoshioka, K., Griffiths, K.M. & Wata, Y. (2005). Public beliefs about treatment and outcome of mental disorders: a comparison of Australia and Japan. *BMC Medicine*, 3, 12.

Jorm, A. & Oh, E. (2009). Desire for social distance from people with mental disorders: a review. *Aust NZ J Psychiatry*, 43, 183-200.

Jorm, A.F. & Wright, A. (2008). Influences on young people's stigmatising attitudes towards peers with mental disorders: national survey of young Australians and their parents. *The British Journal of Psychiatry*, 192, 144-149.

Judd, F. Komiti, A. & Jackson, H. (2008). How does being female assist help-seeking for mental health problems? *Australian and New Zealand Journal of Psychiatry*, 42, 24-29

- Kabir, M., Iliyasu, Z., Abubakar, I.S. & Aliyu, M.H. (2004). Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. *BMC International Health and Human Rights*, 4(1), 3.
- Kadri, N., Manoudi, F., Berrada, S. & Moussaoui, D. (2004). Stigma impact on Moroccan families of patients with schizophrenia. *Canadian Journal of Psychiatry*, 49(9), 625-629.
- Kahng, S.K. & Mowbray, C. (2004). Factors influencing self-esteem among individuals with severe mental illness: Implications for social work. *Social Work Research*, 28(4), 225-237.
- Kaiser, H. (1970). A second generation Little Jiffy. *Psychometrika*, 39, 31-6.
- Kakuma, R., Minas, H., van Ginneken, N. et al. (2011). Human resources for mental health care: Current situation and strategies for action. *Lancet*, 378(9803), 1654-1663.
- Kamya, H.A. (2001). African immigrants in the United States: The challenge for research and practice. *Social Work*, 42(2), 154-165.
- Kassam, N. (1997). *Telling it like it is: Young Asian women talk*. London: Livewire/Women's Press.
- Kate, N., Grover, S., Kulhara, P. & Nehra, R. (2012). Supernatural beliefs, aetiological models and help seeking behaviour in patients with schizophrenia. *Ind Psychiatry J*, 21(1), 49-54.
- Katung, P.Y. (2001). Socio-economic factors responsible for poor utilisation of the primary health care services in a rural community in Nigeria. *Niger J Med*, 10(1), 28-9.
- Keane, M. (1991). Acceptance vs. rejection: Nursing students' attitudes about mental illness. *Perspectives in Psychiatric Care*, 27(3), 13-18.
- Keating, F. (2007). African and Caribbean men and mental health: a race equality foundation briefing paper. London: Race Equality Foundation.
- Keating, F., Robertson, D., McCulloch, A. & Francis, E. (2002). Breaking the circles of fear: a review of the relationship between mental health services and African and Caribbean communities. London: The Sainsbury Centre for Mental Health.
- Keating F. & Robertson, D. (2004). Fear, black people and mental illness. A vicious circle? *Health and Social Care in the Community* 12(5), 439-447.
- Kellermann, P.N. (2001). Psychopathology in children of Holocaust survivors: A review of the research. *Israel Journal of Psychiatry and Related Sciences*, 38(1), 36-46.
- Kelly, L.S. & McKenna, H.P. (1997). Victimization of people with enduring mental illness in the community. *Journal of Psychiatric and Mental Health Nursing*, 4, 185-191.
- Kelly, C., Jorm, A. & Wright, A. (2007). Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Med J Aust*, 187(7), 26-30.
- Kemali, D., Maj, M., Veltro, F., Crepet, P. & Locrace, S. (1989). Sondaggio sulle opinioni degli italiani nei riguardi dei malati di mente e della situazione dell'assistenza psichiatrica. *Riv Sper Freniatr, (Suppl 5)*, 1301-51.

- Kermode, M., Bowen, K., Arole, S., Pathare, S. & Jorm, A.F. (2009). Attitudes to people with mental disorders: a mental health literacy survey in a rural area of Maharashtra, India. *Soc Psychiatry Psychiatr Epidemiol.* 44(12), 1087-96.
- Kessler, R.C., Berglund, P.A., Bruce, M.L. et al. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, 36(6), 987-1007.
- Keusch, G.T., Wilentz, J. & Kleinman, A. (2006). Stigma and global health: Developing a research agenda. *Lancet*, 367, 525-527.
- Keynejad, R. (2008). *Barriers to seeking help: What stops ethnic minority groups in Redbridge accessing mental health services?* Essex: RedbridgeCVS.
- Khandelwal, S.K. & Workneh, F. (1986). Perception of mental illness by medical students. *Indian Journal of Psychological Medicine*, 9, 26-32.
- Khoweiled, A. (2005). Attitude of a Sample of Egyptian General Practitioners and Newly Graduated Medical Students towards Psychiatric Illness. *The Egyptian Journal of Mental Health*, 42, 1-29.
- Kiefer, C.A. (2001). Out of the closet: Escaping the stigma. *Psychiatric Rehabilitation Journal*, 24(3), 303-305.
- King, P., Judd, F. & Grigg, M. (2001). A Model for Consultation Liaison Psychiatry in the Loddon Southern Mallee Region for Victoria Project Report. Bendigo: Bendigo Health Care Group Psychiatric Services.
- Kitchener, B.A. & Jorm, A.F. (2002). Mental health first aid training for the public: evaluation of effects on knowledge, attitudes and helping behavior. *BMC Psychiatry*, 2, 10.
- Kleinman, A.M. (1977). Depression, somatization and the 'new cross-cultural psychiatry'. *Social Science and Medicine*, 11, 3-10.
- Kleinman, A.M. (1980). *Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine, and psychiatry*. Berkeley: University of California Press
- Kleinman, A.M. (1987). Anthropology and psychiatry: The role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, 151, 447- 454.
- Kleinman, A.M. (2009). Global mental health: A failure of humanity. *Lancet*, 374, 603–604.
- Kleintjes, S., Lund, C. & Flisher, A.J. (2010). MHAPP Research Programme Consortium. A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia. *African Journal of Psychiatry*, 13, 132-139.
- Kobau, R., DiIorio, C., Chapman, D. & Delvecchio, P. (2010). Attitudes About Mental Illness and its Treatment: Validation of a Generic Scale for Public Health Surveillance of Mental Illness Associated Stigma. *Community Mental health Journal*, 46, 164-176.

- Koenig, H. G. (2008). Religion and mental health: what should psychiatrists do? *Psychiatrist* 32, 201–203.
- Kohn, R. & Levav, I. (2000). PTSD an explanation for affective disorder among Jews: a response. *History of Psychiatry*, 11, 341–343.
- Komiti, A. Judd, F & Jackson, H. (2006). The influence of stigma and attitudes on seeking help from a GP for mental health problems: A rural context. *Soc Psychiatry Psychiatr Epidemiol*, 41, 738–745.
- Kottek, S.S. (1992). The image of the insane in ancient Jewish lore. *Medicine and Law*, 11(7–8), 653–660.
- Kovess-Masfety, V., Alonso, J., Brugha, T.S. et al. (2007). Difference in lifetime use of services for mental health problems in six European countries. *Psychiatry*, 58, 213–220.
- Kunda, Z. & Oleson, K.C. (1995). Maintaining stereotypes in the face of disconfirmation: Constructing grounds for subtyping deviants. *Journal of Personality and Social Psychology*, 68, 565–579.
- Kunda, Z. & Oleson, K.C. (1997). When exceptions prove the rule: How extremity of deviance determines the impact of deviant examples on stereotypes. *Journal of Personality and Social Psychology*, 72, 965–979.
- Kung, W.W. (2003). The illness, stigma, culture, or immigration? Burdens on Chinese American caregivers of patients with schizophrenia. *Families in Society*, 84(4), 547–557.
- Kurihara, T., Kato, M., Reverger, R. & Tirta, I. (2006). Beliefs about causes of schizophrenia among family members: a community-based survey in Bali. *Psychiatr Serv*, 57, 1795–1799.
- Lahariya, C., Singhai, S., Gupta, S. & Mishra, A. (2010). Pathway of care among psychiatric patients attending a mental health institution in central India. *Indian J Psychiatry*. 52(4), 333–338.
- Lambo, T.A. (1978). Psychotherapy in Africa. *Human Nature*, 1(3), 32–39.
- Landrine, H. & Klonoff, E. A. (1994). Cultural diversity in causal attributions for illness: The role of the supernatural. *J. Behav. Med.*, 17, 181–193.
- Larson, J.E. & Corrigan, P. (2008). The stigma of families with mental illness. *Acad Psychiatry*, 32, 87–91.
- Larsen, T.K., Mcglashan, T.H. & Moe, L.C. (1996). First-episode schizophrenia: 1. Early course parameters. *Schizophr bull*, 22, 241–256.
- Lauber, C. & Rössler, W. (2007). Stigma towards people with mental illness in developing countries in Asia. *International Review of Psychiatry*, 19, 157–178.
- Lauria-Horner, B.A., Kutcher, S. & Brooks, S.J. (2004). The feasibility of a mental health curriculum in elementary school. *Canadian Journal of Psychiatry*, 49, 208–211.

- Lawani, A.O. (2008). The Nigerian society as a psychiatric patient. Paper presented at the Annual Scientific Conference and workshop of Nigerian Association of Clinical Psychologists. Benin City, Nigeria.
- Leaf, P.J., Livingston, M. & Tischler, G.L. (1986). The differential effect of attitudes on the use of mental health services. *Social Psychiatry*, 21, 187-192.
- Lecrubier, Y. (2005). Posttraumatic stress disorder in primary care: A hidden diagnosis. *Journal of Clinical Psychiatry*, 65, 49-54.
- Leff, J. & Warner, R. (2006). *Social Inclusion of People with Mental Illness*. Cambridge: Cambridge University Press.
- Le Meyer, O., Zane, N., Cho, Y.I. & Takeuchi, D.T. (2009). Use of specialty mental health services by Asian Americans with psychiatric disorders. *Journal of Consulting and Clinical Psychology*, 77(5), 1000-1005.
- Leininger, M. & McFarland, M.R. (2002). *Transcultural Nursing: Concepts, theories, research and practice*. New York: McGraw Hill Co.
- Leong, F & Lau, A. (2001). Barriers to providing effective mental health services to Asian Americans. *Ment Health Services Research*, 3, 201-214.
- Levav, I., Shemesh, A., Grinshpoon, A. Aisenberg, E., Shershevsky, Y. & Kohn, R. (2004). Mental health-related knowledge, attitudes and practices in two kibbutzim. *Soc Psychiatry Psychiatr Epidemiol* 39, 758-764.
- Levey, S. & Howells, K. (1994). Accounting for the fear of schizophrenia. *Journal of Community & Applied Social Psychology*, 4, 313-328.
- Levey, S. & Howells, K. (1995). Dangerousness, unpredictability and the fear of people with schizophrenia. *Journal of Forensic Psychiatry*, 6, 19-39.
- LeVine, R. (1966). *Dreams and Deeds: Achievement Motivation in Nigeria*. Chicago: The University of Chicago Press.
- Liang, B., Goodman, L., Tummala-Narra, P. & Weintraub, S. (2005). A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence. *American Journal of Community Psychology*, 36, 71-84.
- Liberman, R.P. (2008). *Recovery from disability: Manual of psychiatric rehabilitation*. Washington, DC: American Psychiatric Publishing.
- Liggins, J. & Hatcher, S. (2005). Stigma toward the mentally ill in the general hospital: a qualitative study. *Gen Hosp Psychiatry*, 27, 359-64.
- Lin, E., Goering, P., Offord, D.R., Campbell, D. & Boyle, M.H. (1996). The use of mental health services in Ontario: epidemiologic findings. *Can J Psychiatry*, 41, 572-577.
- Lin, K.M., Inui, T.S., Kleinman, A.M. & Womack, W.M. (1982). Sociocultural determinants of the help-seeking behavior of patients with mental illness. *J Nerv Ment Dis.*, 170(2), 78-85.

- Lincoln, C.V. & McGorry, P. (1995). Who cares ? Pathways to psychiatric care for young people experiencing a first episode of psychosis. *Psychiatric Services*, 46, 1166-1171.
- Link, B.G. (1982). Mental patient status, work, and income: An examination of the effects of a psychiatric label. *Am Sociol Rev*, 47, 202-215.
- Link, B.G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, 52, 96-112.
- Link, B.G., Cullen, F.T., Struening, E.L., Shrout, P.E. & Dohrenwend, B.P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review*, 54, 400-423.
- Link, B.G., Mirotznik, J. & Cullen, F.T. (1991). The effectiveness of stigma coping orientations: Can negative consequences of mental illness labeling be avoided? *Journal of Health and Social Behavior*, 32, 302-320.
- Link, B.G. & Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385.
- Link, B.G. & Phelan, J.C. (2006). Stigma and its public health implications. *Lancet*, 367, 528-529.
- Link, B.G., Phelan, J.C., Bresnahan, M., Stueve, A. & Pescosolido, B.A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *Am J Public Health*, 89, 1328-1333.
- Link, B.G., Struening, E.L., Neese-Todd, S., Asmussen, A. & Phelan, J.C. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services*, 52, 1621-1626.
- Link, B.G., Struening, E.L., Rahav, M., Phelan, J.C. & Nuttbrock, L. (1997). On stigma and its consequences: evidence from a longitudinal study of men with dual diagnosis of mental illness and substance abuse. *Journal of Health and Social Behaviour*, 38, 177-190.
- Link, B.G., Yang, L.H., Phelan, J.C. & Collins, P.Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin*, 30, 511-541.
- Litwak, E. (1968). Technological innovation and theoretical functions of primary groups and bureaucratic structures. *Am J Sociology*, 73, 468-481.
- Livaditis, M. (1994). *Psychiatry and the Law*. Athens Greece: Papazissis.
- Logan, D.E. & King, C.A. (2001). Parental facilitation of adolescent mental health service utilization: A conceptual and empirical review. *Clinical Psychology: Science and Practice*, 8, 319-340.
- Lowe, T., Bond, K., Spokes, K. & Wellman, N. (2002). HOVIS - The Hertfordshire and Oxfordshire Violent Incident Study. *Journal of Psychiatric and Mental Health Nursing*, 9(2), 199-211.

- Maccoby, E. E. (1990). Gender and relationship: A development account. *American Psychologist*, 45, 513-420.
- Mackenzie, C.S., Gekoski, W.L. & Knox, V.J. (2006): Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Aging & Mental Health*, 10(6), 574-582.
- MacKian, S. (2003). *A review of health seeking behaviour: problems and prospects*. Manchester: The University of Manchester, Health Systems Development Programme.
- MacLachlan, M. (1997). *Culture and health*. Chichester, UK: Wiley.
- MacPhail, C. & Campbell, C. (2001). 'I think condoms are good but, aai, I hate those things': condom use among adolescents and young people in a Southern African township. *Social Science and Medicine*, 25(11), 1613-1627.
- Magliano, L., Fiorillo, A., de Rosa, C., Malangone, C. & Maj, M. (2004). Beliefs about schizophrenia in Italy: a comparative nationwide survey of the general public, mental health professionals, and patients' relatives. *Can J Psychiatry*, 49, 322-330.
- Magliano, L., Fiorillo, A., de Rosa, C., Malangone, C., & Maj, M. (2005). Family burden in long-term diseases: A comparative study in schizophrenia vs. physical disorders. *Social Science & Medicine*, 61, 313-322.
- Makanjuola, V., Doku, V., Jenkins, R. & Gureje, O. (2012). Impact of a one-week intensive 'training of trainers' workshop for community health workers in South-West Nigeria. *Mental Health Family Med.* 9, 33-8.
- Marie, D. & Miles, B. (2008). Social distance and perceived dangerousness across four diagnostic categories of mental disorder. *Australian and New Zealand Journal of Psychiatry*, 42, 126-133.
- Markowitz, F.E. (1998). The effects of stigma on the psychological wellbeing and life satisfaction of people with mental illness. *Journal of Health and Social Behavior*, 39, 335-347.
- Martin, J.K., Pescosolido, B.A., Olafsdottir, S. & McLeod, J.D. (2007). The construction of fear: Americans' preferences for social distance from children and adolescents with mental health problems. *J Health Soc Behav*, 48, 50-67.
- Martin, J.K., Pescosolido, B.A. & Tuch, S.A. (2000). Of fear and loathing: the role of 'disturbing behaviour', labels, and causal attribution in shaping public attitudes toward people with mental disorder. *J Health Soc Behav*, 41, 208-223.
- Martin, S. (2009). Illness of the mind or illness of the spirit? Mental health-related conceptualization and practices of older Iranian immigrants. *Health & Social Work*, 34, 117-126.
- Martinez, M.A. (2010). *The Blame Game: Lay causal theories and familiarity with mental illness*. Senior Thesis in Psychology.

- Matheson, S.L., Shepherd, A.M., Laurens, K. R. & Carr, V. J. (2011). A systematic meta-review grading the evidence for non-genetic risk factors and putative antecedents of schizophrenia. *Schizophrenia Research*, 133, 133-142.
- Maughan, B. (2005). Educational Attainments: Ethnic Differences in the United Kingdom. In M. Rutter & M. Tienda (Eds.) *Ethnicity and Causal Mechanisms*. (pp 80-106). New York: Cambridge University Press.
- Mbanga, N.I., Niehaus, D.J., Mzamo, N.C. et al. (2002). Attitudes towards and beliefs about schizophrenia in Xhosa families with affected probands. *Curationis*, 25, 69-73.
- McAlpine, D.D. & Mechanic, D. (2000). Utilization of speciality mental health care among persons with severe mental illness: the roles of demographics, need, insurance and risk. *Health Services Research*, 35, 277-292.
- McCabe, R. & Priebie, S. (2004). Explanatory models of illness in schizophrenia: comparison of four ethnic groups. *British Journal of Psychiatry*, 185, 23-30.
- McCombie, S.C. (2002). Self-treatment for malaria: the evidence and methodological issues. *Health Policy and Planning*, 17, 333-344.
- McConachie, S. & Whitford, H. (2009). Mental health nurses' attitudes towards severe perinatal mental illness. *Journal of Advanced Nursing*, 65(4), 867-876.
- McLachie, L. & Draguns, J. (1984). Mental health concepts of evangelical Protestants. *The Journal of Psychology*, 118, 147-159.
- Mehta, N., Kassam, A., Leese, M., Butler, G. & Thornicroft, G. (2009). Public attitudes towards people with mental illness in England and Scotland, 1994-2003. *Br J Psychiatry*, 194(3), 278-84.
- Meltzer, H., Bebbington, P.E., Brugha, T.S., Farrell, M., Jenkins, R. & Lewis, G. (2000). The reluctance to seek care for neurotic disorders. *Journal of Mental Health*, 9, 319-327.
- Menon, U. (2001). Middle adulthood in cultural perspectives: The imagined and the experienced in three cultures. In M. E. Lachman (ed.), *Handbook of midlife development* (pp. 40-74). New York: Wiley.
- Mental Health Foundation (2002). *Taken seriously: The Somerset spirituality project*. London: Mental Health Foundation.
- Mesquita, B. (2001). Emotions in collectivist and individualist contexts. *Journal of Personality and Social Psychology*, 80, 68-74.
- Meyer, B. (2004). Christianity in Africa: From African Independent to Pentecostal-Charismatic Churches. *Annual Review of Anthropology*, 33, 447-474.
- Minas, H. & Cohen, A. (2007). Why focus on Mental Health Systems? *International Journal of Mental Health Systems*, 1(1).
- Minas, H. & Diatri, H. (2008). Pasung: physical restraint and confinement of the mentally ill in the community. *Int J Mental Health Syst*, 2(8).

- Minas, H., Klirnidis, S. & Tuncer, C. (2007). Illness causal beliefs in Turkish immigrants. *BMC Psychiatry*, 7(10).
- Minas, I.H. (1996). *Mental health services for NESB immigrants. Bureau of immigration. Multi-cultural and population research*. Canberra: Australian Government Publishing Service.
- Ministry of Health (2004). *Improving Mental Health: The Second National Mental Health and Addiction Plan 2005 – 2015; Consultation Document*. Wellington. MoH.
- Mino, Y., Kodera, R. & Bebbington, P.A. (1990). Comparative study of psychiatric services in Japan and England. *Br. J. Psychiatry*, 157, 416-420.
- Mishra, S.I., Lucksted, A., Gioia, D., Barnet, B. & Baquet, C.R. (2009). Needs and preferences for receiving mental health information in an African American focus group sample. *Community Mental Health Journal*, 45, 117-126.
- Mitchell, P., Malak, A. & Small, D. (1998). Bilingual professionals in community mental health services. *Australian and New Zealand Journal of Psychiatry*, 32, 424-439.
- Mkize, L.P. & Uys, L.R. (2004). Pathways to mental health care in KwaZulu-Natal. *Curationis* 27(3), 62-71.
- Modrow, J. (2003). *How to become a schizophrenic; the case against biological psychiatry*. Lincoln, Nebraska: The Writers Club Press.
- Mohammed, S. & Mohammed, S.K. (2008). Attitudes towards mental illness in a Malay Army Battalion. *Medical Journal of Asia*, 7(2), 21-32.
- Moldovan, V. (2007). Attitudes of Mental Health Workers toward Community Integration of the Persons with Serious and Persistent Mental Illness. *American Journal of Psychiatric Rehabilitation*, 10(1), 19-30.
- Moller-Leimkuhler, A.M. (2002). Barriers to help-seeking by men: A review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders*, 71, 1-9.
- Monahan, J. (2000). Clinical and Actuarial Predictions of Violence in D. Faigman, D. Kaye, M. Saks, and J. Sanders (Editors), *Modern Scientific Evidence: The Law and Science of Expert Testimony* Vol. 1. Pgs. 300-218. St. Paul MN: West Publishing Company:
- Monteiro, V.B.M., Dos Santos, J.Q. & Martin, D. (2006). Patients' relatives delayed help seeking after a first psychotic episode. *Revista Brasileira de Psiquiatria*, 28, 104-110.
- Monteith, M.J. (1996). Affective reactions to prejudice-related discrepant responses: the impact of standard salience. *Person Soc Psychol Bull*, 22, 48-59.
- Morgan, C., Mallett, R., Hutchinson G. et al. (2005). Pathways to care and ethnicity. 1: Sample characteristics and compulsory admission. Report from the AESOP study. *British Journal of Psychiatry*, 186, 281-289.

- Muga, F.A. & Jenkins, R. (2008). Public perceptions, explanatory models and service utilization regarding mental illness and mental health care in Kenya. *Soc Psychiatry Psychiatr Epidemiol*, 43, 469-476.
- Muirhead, J. & Tilley, J. (1995). Scratching the surface: Mental health training for rural health workers. *Australian and New Zealand Journal of Mental Health Nursing*, 4(2), 95-98.
- Mulatu, M.S. (1999). Perceptions of mental and physical illnesses in north-western Ethiopia: Causes, treatments, and attitudes. *Journal of Health Psychology*, 4(4), 531-549.
- Munro, S. & Baker J.A. (2007). Surveying the attitudes of acute mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, 14, 196-202.
- Murthy, R.S. (2001, August 14). Lessons from Erwadi. Retrieved from <http://www.hindu.com/thehindu/2001/08/14/stories/05142524.htm>
- Mukherjee, R., Fialho, A., Wijetunge, A., Chesinski, K. & Surgenor, T. (2002). The stigmatization of psychiatric illness: the attitudes of medical students and doctors in a London teaching hospital. *Psychiatr Bull*, 26, 178-181.
- Naeem, F., Ayub, M. & Javid, Z. (2006). Stigma and Psychiatric Illness. A Survey of Attitude of Medical Students and Doctors in Lahore, Pakistan. *J Ayub Med Coll Abbottabad*, 18(3).
- Nah, K.H. (1990). Korean immigrants in New York: Needs, problems and help seeking behavior. Unpublished Doctoral dissertation. New York: Columbia University.
- Nakane, Y., Jorm, A., Yoshioka, K., Christensen, H., Nakane, H. & Griffiths, K.M. (2005). Public beliefs about causes and risk factors of mental disorders: a comparison of Japan and Australia. *BMC Psychiatry*, 5, 33.
- National Alliance on Mental Illness (2008, May 27). Schizophrenia: Public attitudes, personal needs. Retrieved from <http://www.nami.org/>
- National Institute for Mental Health in England (2003). *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*. London: Department of Health:
- Ndeti, D.M., Khasakhala, L.I., Mutiso, V. & Mbwaiyo, A.W. (2011). Knowledge, attitude and practice (KAP) of mental illness among staff in general medical facilities in Kenya: practice and policy implications. *African Journal of Psychiatry*, 14, 225-235.
- Needham, I., Abderhalden, C., Dassen, T., Haug, H. J. & Fischer, J.E. (2002). Coercive procedures and facilities in Swiss psychiatry. *Swiss Medical Weekly*, 132, 253-258.
- Neto, F. (2002). Loneliness and acculturation among adolescents from immigrant families in Portugal. *Journal of Applied Social Psychology*, 32, 630-647.
- Ngulde, A.M. (2013, March 7). The Igbos will never rule Nigeria again. Daily Post online. Retrieved from <http://dailypost.ng/2013/05/19/abubakar-mamman-ngulde-the-igbos-will-never-rule-nigeria-again/>

- Nichter, M. (1981). Idioms of distress: alternatives in the expression of psychosocial distress: a case study from South India. *Cult Med Psychiatry*, 5(4), 379-408.
- Nickerson, K.J., Helms, J.E. & Terrell, F. (1994). Cultural mistrust, opinions about mental illness and black students' attitudes toward seeking psychological help from white counselors. *Journal of Counseling Psychology*, 41(3), 378-385.
- Nicolaidis, C., Timmons, V., Thomas, M.J. et al. (2010). "You don't go tell White people nothing": African-American women's perspectives on the influence of violence and race on depression and depression care. *American Journal of Public Health*, 100(8), 1470-6.
- Nina, A. (2009). International Students' Awareness and Use of Counseling Services. *McNair Scholars Research Journal*, 5, 29-33.
- Nobles, A.Y. & Sciarra, D.T. (2000). Cultural determinants in the treatment of Arab Americans: A primer for mainstream therapist. *American Journal of Orthopsychiatry*, 70, 182-191.
- Nsereko, J.R., Kizza, D., Kigozi, F. et al. (2011). Stakeholder's perceptions of help-seeking behaviour among people with mental health problems in Uganda. *International Journal of Mental Health Systems* 5(5).
- Nursing Council of New Zealand (2002). *Guidelines for Cultural Safety. The Treaty of Waitangi and Maori Health in Nursing and Midwifery Education and Practice*. Wellington. Nursing Council of New Zealand.
- Nwoko, K.C. (2009). Traditional psychiatric healing in Igbo land, Southeastern Nigeria. *African Journal of History and Culture*, 1(2), 036-043.
- Nwokocha, F. I. (2010). *West African Immigrants in Northern California and their Attitudes toward Seeking Mental Health Services*. Unpublished MA Dissertation. California State University, Sacramento.
- Nwolisa, O. & Eloka, C.P. (2003). *Njepu Amaka - Migration Is Rewarding: A Sociocultural Anthropological Study of Global Economic Migration*. Oxford: Peter Lang Pub Inc.
- Nyagua, J.Q. & Harris, A.J. (2007). West African refugee health in rural Australia: Complex cultural factors that influence mental health. *African Journal of History and Culture*, 1(2), 36-43.
- Nzewi, N. E. (1989). Cultural factors in the classification of Psychopathology in Nigeria. In K. Peltzer and P.O.Ebigbo (Eds.), *Clinical Psychology in Africa* (pp. 208-216). Enugu: Chuka Printing Company Ltd.
- Obioha, E.E. & Molale, M.G. (2011). Functioning and Challenges of Primary Health Care (PHC) Program in Roma Valley, Lesotho. *Ethno Med*, 5(2), 73-88.
- Odejide, A.O. (1978). Traditional (native) psychiatric practice; its role in modern psychiatry in a developing country. *The Psychiatric J Univ Ottawa*, 4, 297-301.
- Odejide, A.O. & Olatawura, M.O. (1979). A survey of community attitudes to the concept and treatment of mental illness in Ibadan, Nigeria. *Nigerian Med J*, 9, 343-347.

- Odejide, O.A., Oyewunmi, K.L. & Ohaeri, J.U. (1989). Psychiatry in Africa: An overview. *Am J Psychiatry*, 146, 708-716.
- Odejide, A.O., Morakinyo, J.J., Oshiname, F.O., Omigbodun, O., Ajuwon, A.J. & Kola, L. (2002). Integrating mental health into primary health care in Nigeria: management of depression in a local government (district) area as a paradigm. *Seishin Shinkeigaku Zasshi*, 104(10), 802-9.
- Odinka, P.C., Oche, M., Ndukuba, A.C. et al. (2014). The Socio-demographic Characteristics and Patterns of Help-Seeking among Patients with Schizophrenia in South-east Nigeria. *Journal of Health Care for the Poor and Underserved*, 25(1), 180-191.
- Office of National Statistics. (1995). Labour Force Survey. London: Office of National Statistics.
- Ogborn, A.C. (1995). Characteristics of youth and young adults seeking residential treatment for substance use problems: An exploratory study. *Addictive Behavior*, 20(5), 675-678.
- Oghojafor, B.E.A., Alaneme, G.C. & Kuye, O.L. (2013). Indigenous Management Thoughts, Concepts and Practices: The Case of the Igbos of Nigeria. *Australian Journal of Business and Management Research*, 3, 01.
- Ogrodniczuk, J.S., Joyce, A.S. & Piper, W.E. (2005). Strategies for reducing patient-initiated premature termination of psychotherapy. *Harv Rev Psychiatry*. 13(2), 57-70.
- Ohaeri, J.U. (1988). African traditional medicine: a stage in the people's history. *Afr Notes*, 12, 24-28.
- Ohaeri, J.U. & Fido, A.A. (2001). The opinion of caregivers on aspects of schizophrenia and major affective disorders in a Nigerian setting. *Social Psychiatry and Psychiatric Epidemiology*, 36(10), 493-499.
- Ohaeri, J.U. (2001). Caregiver Burden and Psychotic Patient's Perception of Social Support in a Nigerian Setting. *Soc Psychiatry Psychiatr Epidemiol*. 36(2), 86-93.
- Okafor, E.B. (2009). *The relation between demographic factors and attitudes about seeking professional counseling among adult Nigeria living in the United States*. Unpublished doctoral dissertation, University of Akron, Ohio.
- Okhomina, F.O. & Ebie, J.C. (1973). Heat in the head as a Psychiatric symptom. In C.C. Adonakoh (Ed.), *Proceedings of the 4th Pan African Psychiatric Congress workshop on Neurosis in Africa*. Accra: New Times Corporation.
- Oko, K.A. (2011). Aetiology of Igbo Cultural Rites (a case study of Abiriba Community): implications for counselling. *Edo Journal of Counselling*, 4, 1-2.
- Okpi, A. (2013, August 26). Deporting the Igbo from Lagos insulting – Ohanaeze. Punch Newspaper Online, Retrieved from <http://www.punchng.com/politics/crossfire/deporting-the-igbo-from-lagos-insulting-ohanaeze/>

- Olofsson, B. & Jacobsson, L. (2001). A plea for respect: involuntarily hospitalized psychiatric patients' narratives about being subjected to coercion. *Journal of Psychiatric and Mental Health Nursing*, 8, 357-366.
- Omigbodun, O.O. (2001). A Cost-Effective Model for Increasing Access to Mental Health Care at the Primary Care Level in Nigeria. *The Journal of Mental Health Policy and Economics*, 4, 133-139.
- Onwuejeogwu, M.A. (1986). *African Indigenous Ideology: Communal-Individualism*. University of Benin Inaugural Lecture series 24. Benin City, Nigeria.
- Ovuga, E. Boardman, J. & Oluka, E.G.A.O. (1999). Traditional healers and mental illness in Uganda. *Psychiatric Bulletin*, 23, 276-279.
- Oyedeji, A., Ayorinde, E. Gureje, O. & Rahman, L. (2004). Psychiatric research in Nigeria: bridging tradition and modernisation. *British Journal of Psychiatry*, 184(6), 536-538.
- Oyegbile, O. (2009). A Maddening Headache. *Tell Magazine*, 22, 47-50.
- Ozmen, E., Ogel, K., Aker, T., Sagduyu, A., Tamar, D. & Boratav, C. (2004). Public attitudes to depression in urban Turkey: the influence of perceptions and causal attributions on social distance towards individuals suffering from depression. *Soc Psychiatry Psychiatr Epidemiol*, 39, 1010-1016.
- Ozturk, O.M. & Volcan, V.D. (1971). The theory and practice of psychiatry in Turkey. *Am. J. Psychother*, 25, 240-271.
- Pachankis, J.E. (2007). The psychological implications of concealing a stigma: a cognitive-affective-behavioral model. *Psychol Bull*, 133, 328-345.
- People advocating for change through empowerment (PACE) (1996). *Surviving in Thunder Bay: An Examination of Mental Health Issues*. Thunder Bay, Ontario.
- Packer, S., Prendergast, P., Wasylenki, D., Toner, B. & Ali, A. (1994). Psychiatric residents' attitudes toward patients with chronic mental illness. *Hospital and Community Psychiatry*, 45(11), 1117-1121.
- Papadopoulos, C., Leavey, G. & Vincent, C. (2002). Factors influencing stigma: a comparison of Greek-Cypriot and English attitudes towards mental illness in north London. *Social Psychiatry & Psychiatric Epidemiology*, 37, 430- 434.
- Parish, C. (2004). Bennett inquiry finds services scarred by pervasive racism. *Mental Health Practice*, 7(6), 4.
- Park, L., Xiao, Z., Worth, J. & Park, J. (2005). Mental health Care in China: Recent Changes and Future Challenges. *Harvard Health Policy Review*, 6, 35-45.
- Parr, H. & Philo, C. (2003). Rural mental health and social geographies of caring. *Social and Cultural Geography*, 4, 471-488.

- Patel, V. (1995). Explanatory models of mental illness in sub-Saharan Africa. *Soc Sci Med*, 40, 1291-1298.
- Patel, V., Araya, R., Chatterjee, S. et al. (2007). Treatment and Prevention of Mental Disorders in Low-income and Middle-income Countries. *Lancet*, 370(9591), 991-1005.
- Patel, V., Cohen, A., Thara, R. & Gureje, O. (2006). Is the outcome of schizophrenia really better in developing countries? *Rev Bras Psiquiatr*. 28(2), 149-52.
- Patel, V., Musara, T., Batau, T., Maramba, P. & Fuyane, S. (1995). Concepts of mental illness and medical pluralism in Harare. *Psychological Medicine*, 25(3), 485-493.
- Patel, V. & Sumathipala, A. (2001). International representation in psychiatric literature: Survey of six leading journals. *British Journal of Psychiatry*, 178, 406-409.
- Paterson, B. (2006). *Newspaper representations of mental illness and the impact of the reporting of events on social policy: the 'framing' of Isabel Schwarz and Jonathan Zito*. *Journal of Psychiatric and Mental Health Nursing*, 13, 294-300.
- Pearce, T.O. (1989). *Social Organisation and Psychosocial Health*. In K. Peltzer & P.O.Ebigbo (Eds.) *Clinical Psychology in Africa* (pp. 47-55). Enugu: Chuka Printing Company Ltd.
- Peeters, F.P.M.L. & Bayer, H. (1999). 'No-show' for initial screening at a community mental health centre: rate, reasons and further help-seeking. *Soc Psychiatry Psychiatr Epidemiol*, 34, 323-327.
- Pelletier, J., Davidson, L., Roelandt, J. & Daumerie, N. (2009). Citizenship and recovery for everyone: A global model of public mental health. *International Journal of Mental Health Promotion*, 11(4), 45-53.
- Penn, D.L., Guynan, K., Daily, T., Spaulding, W.D., Garbin, C.P. & Sullivan, M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? *Schizophrenia Bulletin*, 20, 567-578.
- Penny, N.H., Kasar, J. & Sinay, T. (2000). Student attitudes toward persons with mental illness: The influence of course work and level II fieldwork. *The American Journal of Occupational Therapy*, 55, 217-220.
- Penny, N.H. (2002). Longitudinal Study of Student Attitudes toward People with Mental Illness. *Occupational Therapy in Mental Health*, 17, 49-80.
- Perlick, D. A., Miklowitz, D.J., Link, B.G. et al. (2007). Perceived stigma and depression among caregivers of patients with bipolar disorder. *British Journal of Psychiatry*, 190, 535-536.
- Perlick, D.A., Rosenheck, R. A., Clarkin, J. F. et al. (2001). Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services*, 52,(12), 1627-1632.
- Perlick, D. A., Rosenheck, R. A., Clarkin, J. F. et al. (2004). Impact of family burden and affective response on clinical outcome among patients with bipolar disorder. *Psychiatric Services*, 55, 1029-1035.

- Persaud, R. (2000). Psychiatrists suffer from stigma too. *Psychiatric Bulletin*, 24, 284-285.
- Petersen, I., Ssebunnya, J., Bhana, A. & Baillie, K. (2011). MhaPP Research Programme Consortium. Lessons from case studies of integrating mental health into primary health care in South Africa and Uganda. *Int J Mental Health Systems*, 5(8).
- Pfeifer, S. (1994). Belief in demons and exorcism in psychiatric patients in Switzerland. *British Journal of Medical Psychology*, 67(3), 247-258.
- Phan, T. (2000). Investigating the use of services for Vietnamese with mental illness. *Journal of Community Health*, 25, 411-425.
- Phelan, J. Bromet, E. & Link, B. (1998). Psychiatric illness and family stigma. *Schizophrenia Bulletin*, 24, 115-126.
- Phelan, J.C., Link, B.G., Stueve, A. & Pescosolido, B.A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared? *Journal of Health and Social Behavior*, 41, 188-207.
- Phelan, J.E. & Basow, S.A. (2007). College students' attitudes toward mental illness: An examination of the stigma process. *Journal of Applied Social Psychology*, 37, 2877-2902.
- Phillips, M.R., Li, Y., Stroup, T.S. & Xin, L. (2000). Causes of schizophrenia reported by patients' family members in China. *Br J Psychiatry*, 177, 20-25.
- Philo, G. (1996). *Media and Mental Distress*. London: Longman.
- Pillai, V., Kalmbach, D.A. & Ciesla, J.A. (2011). A meta-analysis of electroencephalographic sleep in depression: Evidence for genetic biomarkers. *Biological Psychiatry*, 70, 912-919.
- Pilgrim, D. (2009). *Key concepts in mental health*. London: Sage
- Pinel, E.C. (1999). Stigma consciousness: The psychological legacy of social stereotypes. *Journal of Personality and Social Psychology*, 76, 114-128.
- Pinfold, V., Toulmin, H., Thornicroft, G., Huxley, P., Farmer, P. & Graham, T. (2003). Reducing psychiatric stigma and discrimination: Evaluation of educational intervention in UK secondary schools. *British Journal of Psychiatry*, 182, 342-346.
- Pinto-Foltz, M.D. & Logsdon, M.C. (2009). Reducing Stigma Related to Mental Disorders: Initiatives, Interventions, and Recommendations for Nursing. *Archives of Psychiatric Nursing*, 23(1). 32-40.
- Pitre, N., Stewart, S., Adams, S., Bedard, T. & Landry, S. (2007). The use of puppets with elementary school children in reducing stigmatizing attitudes towards mental illness. *Journal of Mental Health*, 16(3), 415-429.
- Platz, C., Umbricht, D.S., Cattapan-Ludewig, K. et al. (2006). Help-seeking pathways in early psychosis. *Social Psychiatry and Psychiatric Epidemiology*, 41, 967-974.

- Polyakova, S.A. & Pacquiao, D.F. (2006). Psychological and mental illness among elder immigrants from the former Soviet Union. *Journal of Trans-cultural Nursing*, 17(1), 40-49.
- Price, E.G., Beach, M.C., Gary, T.L. et al. (2005). A systematic review of the methodological rigor of studies evaluating cultural competence training of health professionals. *Academic Medicine*, 80, 578-586.
- Prince, M., Patel, V., Saxena, S. et al. (2007). No Health without Mental Health. *Lancet*, 370(9590), 859-877.
- Prince, R. (1975). Some Yoruba views of the causes and modes of treatment of anti-social behaviour. *African Journal of psychiatry*, 2, 133-137.
- Putman, S. (2008). Mental illness: diagnostic title or derogatory term? (Attitudes towards mental illness) Developing a learning resource for use within a clinical call centre. A systematic literature review on attitudes towards mental illness. *Journal of Psychiatric and Mental Health Nursing*, 15, 684-693.
- Rahman, A. Mubbashar, M. H., Gater, R., Goldberg, D. (1998). Randomised trial of impact of school mental-health programme in rural Rawalpindi, Pakistan. *Lancet*. 352, 1022-25.
- Randhawa, G. & Stein, S. (2007): An Exploratory Study Examining Attitudes Toward Mental Health and Mental Health Services Among Young South Asians in the United Kingdom. *Journal of Muslim Mental Health*, 2(1), 21-37
- Ralph, R.O. & Corrigan, P.W. (2005). *Recovery in mental illness: Broadening our understanding of wellness*. Washington, DC: American Psychological Association.
- Ranguram, R. & Weiss, M. (2004). Stigma and Somatisation. *The British Journal of Psychiatry*, 185, 174.
- Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A. & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *J Psychiatr Ment Health Nurs*. 16(3), 279-84.
- Raymond, C. (1991). Jails reported to be turning into hospitals for the mentally ill. *Chronicle of Higher Education*, 38(15), A16.
- Razali, S.M., Khan, U.A. & Hasanah, C.I. (1996). Belief in supernatural causes of mental illness among Malay patients: impact on treatment. *Acta Psychiatrica Scandinavia*, 94, 229-233.
- Razali, S.M. & Najib, M.A.M. (2000). Help-seeking pathway among Malay psychiatric patients. *International Journal of Social Psychiatry*, 46, 284-289.
- Read, J. (2007). Why promoting biological ideology increases prejudice against people labelled ‘‘schizophrenic’’. *Australian Psychologist*, 42, 118-128.
- Read, J. & Baker, S. (1996). *Not Just Sticks and Stones: A survey of the stigma, taboos and discrimination experienced by people with mental health problems*. London: Mind.

- Reed, F., & Fitzgerald, L. (2005). The mixed attitudes of nurse's to caring for people with mental illness in a rural general hospital. *International Journal of Mental Health Nursing*, 14, 249-257.
- Regier, D.A., Hirschfield, R.M., Goodwin, F.K., Burke Jr. J.D., Lazar, J.b. & Judd, L.L. (1988). The NMH depression awareness, recognition and treatment programme: structure, aims and scientific basis. *American Journal of Psychiatry*, 145, 1351-1357.
- Regier, A., Narrow, W.E., Rae, S., Manderscheid, W., Locke, Z. & Goodwin, K. (1993). The de facto US mental and addictive disorders service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Arch Gen Psychiatry*, 50, 85-94.
- Repper, J., Sayce, L., Strong, S., Willmot, J. & Haines, M. (1997). *Tall Stories from the Backyard: A survey of 'NIMBY' opposition to community mental health facilities, experienced by key service providers in England and Wales*. London: Mind.
- Richmond, I.C. & Foster, J.H. (2003). Negative attitudes towards people with co-morbid mental health and substance misuse problems: An investigation of mental health professionals. *Journal of Mental Health*, 12(4), 393-403.
- Rickwood, D.J. & Braithwaite, V.A. (1994). Social-psychological factors affecting help-seeking for emotional problems. *Social Science and Medicine*, 39, 563-572.
- Rickwood, D., Deane, F. & Wilson, C. (2007). When and how do young people seek professional help for mental health problems? *Medical Journal of Australia*, 187(7), 35-39.
- Rickwood, D., Deane, F., Wilson, C. & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health*, 4(3).
- Riedel-Heller, S.G., Matschinger, H. & Angermeyer, M.C. (2005). Mental disorders - who and what might help? Help-seeking and treatment preferences of the lay public. *Soc Psychiatry Psychiatr Epidemiol*, 40, 167-174
- Rippon, T.J. (2000). Aggression and violence in health care professions. *Journal of Advanced Nursing*, 31, 452-460.
- Ritsher, J.B., Otilingam, P.G. & Grajales, M. (2003). Internalized stigma of mental illness: Psychometric properties of a new measure. *Psychiatry Research*, 121(1), 31-49.
- Ritsher, J.B. & Phelan, J.C. (2004). Internalized stigma predicts erosion of morale among psychiatric outpatients. *Psychiatry Res.* 129, 257-65.
- Roberts, H. (2001). A way forward for mental health care in Ghana? *Lancet*, 357, 1859.
- Robertson, J.M. & Fitzgerald, L.F. (1992). Overcoming the masculine mystique: alternative forms of assistance among men who avoid counselling. *J Crit Psychologist Couns Ther*, 39, 240-249.
- Roe, D., Swarbrick, M. (2007). A recovery oriented approach to psychiatric medication: guidelines for nurses. *Journal of Psychosocial Nursing*, 45(2), 30-35.

- Rogler, L.H. & Hollingshead, A.B. (1985). *Trapped: Puerto Rican Families and Schizophrenia*. Maplewood, NJ, Waterfront Press.
- Rogler, L.H. & Cortes, D.E. (1993). Help-seeking pathways: A unifying concept in mental health care. *American Journal of Psychiatry*, 150, 554-61.
- Rose, D., Thornicroft G., Pinfold V. & Kassam, A. (2007). 250 ways to label people with mental illness. *BMC Health Services Research* 7, 97.
- Rose, E.D. (2010). *Beliefs about mental illness and attitudes towards seeking help: A study of British Jewry*. Doctoral Dissertation submitted to the University of Hertfordshire, UK.
- Rosenhan, D. L. (1973). On being sane in insane places. *Science*, 179(4070), 250-258.
- Rost, K., Smith, R. & Taylor, J.L. (1993). Rural-urban differences in stigma and the use of care for depressive disorders. *J Rural Health*, 9, 57-62.
- Rudnick, A. & Lundberg, E. (2012). The stress-vulnerability model of schizophrenia: A conceptual analysis and selective review. *Current Psychiatry Reviews*, 8, 337-341.
- Rusch, N., Angermeyer, M.C. & Corrigan, P.W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry*, 20, 529-539.
- Rüsch, N., Corrigan, P.W., Wassel, A. et al. (2009). Self-stigma, group identification, perceived legitimacy of discrimination and mental health service use. *Br J Psychiatry*, 195(6), 551-552.
- Rüsch, N., Evans-Lacko, S.E., Henderson, C., Flach, C. & Thornicroft, G. (2011). Knowledge and attitudes as predictors of intentions to seek help for and disclose a mental illness. *Psychiatric Services*, 62, 675-678.
- Russell, J, Thomson, G. & Rosenthal, D. (2008). International student use of university health and counselling services. *Higher Education*, 56, 59-75.
- Ryder, A., Bean, G. & Dion, K. (2000). Caregiver responses to symptoms of first-episode psychosis: A comparative study of Chinese and Euro-Canadian families. *Transcultural Psychiatry*, 37(2), 255-265.
- Sadock, B.J. & Sadock, V.A. (2007). *Synopsis of psychiatry*. Baltimore: Lippincott Williams and Wilkins.
- Sanchez, F. & Gaw, A. (2007). Mental health care of Filipino Americans. *Psychiatric Services*, 58, 810-815.
- Saravanan, B., Jacob, K.S., Deepak, M.G., Prince, M., David. A.S. & Bhugra, D. (2008). Perceptions about psychosis and psychiatric services: A qualitative study from Vellore, India. *Soc Psychiatry Psychiatr Epidemiol.*, 43, 231-8.
- Sartorius, N. (1998). Stigma: what can psychiatrists do about it? *Lancet*, 352, 1058-1059.
- Sartorius, N. (2002). Iatrogenic stigma of mental illness. *British Medical Journal*, 324, 1470-1471.

Sartorius, N., Gaebel, W., Cleveland, H.R. et al. (2010). WPA guidance on how to combat stigmatization of psychiatry and psychiatrists. *World Psychiatry*, 9, 131-144.

Sartorius, N. (2014). Psychiatry in developed and developing countries. In S. Bloch, S.A. Green, & J. Holman, (Eds.) *Psychiatry: Past, present, and prospect* (pp. 117-132). Oxford: Oxford University Press.

Sayce, L. & Boradman, J. (2003) The Disability Discrimination Act 1995: implications for psychiatrists. *Advances in Psychiatric Treatment*, 9, 397-404.

Sayre, J. (2000). The patient's diagnosis: Explanatory models of mental illness. *Qualitative Health Research*, 10(1), 71-83.

Scheff, T.J. (1966). *Being Mentally Ill: A sociological theory*. New York: Aldine.

Scheffler, R.M. & Miller, A.B. (1991). Differences in mental health service utilization among ethnic subpopulations. *Archives of General Psychiatry*, 48, 475-478.

Schlosser, L. Z. (2006). Affirmative psychotherapy for American Jews. *Psychotherapy: Theory, Research, Practice, Training*, 43(4), 424-435.

Schomerus, G., Kenzin, D., Borsche, J., Matschinger, H. & Angermeyer, M.C. (2007). The association of schizophrenia with split personality is not an ubiquitous phenomenon: results from population studies in Russia and Germany. *Soc Psychiatry Psychiatr Epidemiol*, 42, 780-786.

Schomerus, G. & Angermeyer, M.C. (2008). Stigma and its impact on help-seeking for mental disorders: what do we know? *Epidemiol Psychiatr*, 17(1), 31-7.

Schomerus, G., Schwahn, C.C., Holzinger, A.A., Corrigan, P.W., Grabe, H.J., Carta, M.G. & Angermeyer, M.C. (2012). Evolution of public attitudes about mental illness: A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, 125, 440-452.

Schulze, B. (2007). Stigma and mental health professionals: a review of the evidence on an intricate relationship. *International Review of Psychiatry*, 19(2), 137-155.

Schulze, B. & Angermeyer, M.C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental professionals. *Soc Sci Med*, 56, 299-321.

Schulze, B., Richter-Werling, M., Matschinger, H. & Angermeyer, M.C. (2003). Crazy? So what! Effects of a school project on students' attitudes towards people with schizophrenia. *Acta Psychiatrica Scandinavica*, 107, 142-150.

Scott, J. (2002). Foreign born in U.S. at record high. *The New York Times*, A18.

Seff, E. (2003). Media frames of mental illness: The potential impact of negative frames. *Journal of mental health*, 12(3), 259-269.

Sen, M. (2001). *Death by fire: Sati, dowry death and female infanticide in modern India*. London: Weinfield & Nicolson.

- Shalhoub-Kevorkian, N. (2005). Voice therapy for women aligned with political prisoners: A case study of trauma Palestinian women in the second Intifada. *The Social Service Review*, 79(2), 322-404.
- Shao, W., Williams, J.W., Lee, S., Badgett, R.G., Aaronson, B. & Cornell, J.E. (1997). Knowledge and attitudes about depression among non-generalists and generalists. *The Journal of Family Practice*, 44, 161-168.
- Sharrock, J. & Happell, B. (2000). The role of the consultation- liaison nurse in the general hospital. *Australian Journal of Advanced Nursing*, 18, 34-39.
- Shefer, G., Rose, D., Nellums, L. et al. (2013). 'Our community is the worst': the influence of cultural beliefs on stigma, relationships with family, and help seeking in three ethnic communities in London. *International Journal of Social Psychiatry*, 59(6), 535-44.
- Sheikh, S. & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology*, 35, 326-334.
- Shi, J.J., Gershon, E.S., & Liu, C.Y. (2008). Genetic associations with schizophrenia: Meta-analyses of 12 candidate genes. *Schizophrenia Research*, 104, 96-107.
- Shibre, T., Negash, A., Kullgren, G. et al. (2001). Perception of stigma among family members of individuals with schizophrenia and major affective disorders in rural Ethiopia. *Social Psychiatry and Psychiatric Epidemiology*, 36, 299-303.
- Shulman, N. & Adams, B. (2002). A comparison of Russian and British attitudes towards mental health problems in the community. *Int J Soc Psychiatry*, 48, 266-278
- Sigelman, L. & Welch, S. (1993). The contact hypothesis revisited: Black-White interaction and positive racial attitudes. *Social Forces*, 71, 781-795.
- Simmie, S. & Nunes, J. (2001). *The Last Taboo - A Survival Guide to Mental Health Care in Canada*. Toronto: McClelland & Stewart.
- Sirey, J.A., Bruce, M.L., Alexopoulos, G.S., Perlick, D.A., Friedman, S.J. & Meyers, B.S. (2001). Stigma as a barrier to recovery: Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. *Psychiatric Services*, 52(12), 1615-1620.
- Skinner, L.J., Berry, K.K., Griffith, S.E. & Byers, B. (1995). Generalizability and specificity of the stigma associated with the mental illness label: A reconsideration twenty-five years later. *Journal of Community Psychology*, 23, 3-17.
- Smith, J.P., Tran, G.Q. & Thompson, R.D. (2008). Can the Theory of Planned Behavior Help Explain Men's Psychological Help-Seeking? Evidence for a Mediation Effect and Clinical Implications. *Psychology of Men & Masculinity*, 9(3), 179-192.
- Sorketti, E.A., Zuraida, N.Z. & Habil, M H. (2013). Pathways to mental healthcare in high-income and low-income countries. *International Psychiatry*, 10(2).

- Sorsdahl, K., Stein D.J., Grimsrud, A. et al. (2009). Traditional healers in the treatment of common mental disorders in South Africa. *J Nerv Ment Dis.*, 6, 434-41.
- Song, L.Y., Chang, L.Y., Shih, C.Y., Lin, C.Y. & Yang, M.J. (2005). Community attitudes towards the mentally ill: the results of a national survey of the Taiwanese population. *International Journal of Social Psychiatry*. 51(2), 162-76.
- Sosowsky, L. (1980). Explaining the increased arrest rate among mental patients: A cautionary note. *American Journal of Psychiatry*, 137, 1602-1604.
- South African Federation of Mental health. (2011). Understanding mental illness. Mental Illness Info packs.
- Soyka, M. (2000). Substance misuse, psychiatric disorder and violent and disturbed behaviour. *British Journal of Psychiatry*, 176, 345-350.
- Spinelli, M. (2004). Maternal Infanticide associated with mental illness: prevention and the promise of saved lives. *The American Journal of Psychiatry*, 161(9), 1548-1577.
- Steadman, H.J. (1981). Critically reassessing the accuracy of public perceptions of the dangerousness of the mentally ill. *Journal of Health and Social Behavior*, 22, 310-316.
- Steadman, H.J., McCarty, D.W. & Morrissey, J.P. (1989). *The Mentally Ill in Jail: Planning for Essential Services*. New York: The Guilford Press.
- Stern, G., Cottrell, D. & Holmes, J. (1990). Patterns of attendance of child psychiatry out-patients with special reference to Asian families. *British Journal of Psychiatry*, 156, 384-387.
- Stevens, J. Applied multivariate statistics for the social sciences (3rd edn). Mahwah, NJ: Lawrence Erlbaum. 1996.
- Stout, P.A., Villegas, J. & Jennings, N.A. (2004). Images of mental illness in the media: identifying gaps in the research. *Schizophr Bull*, 30, 543-561.
- Stuart, H. & Arboleda-Florez, J. (2001a). Community attitudes towards people with schizophrenia. *Can J Psychiatry*, 46, 245-252.
- Stuart, H. & Arboleda-Florez, J. (2001b). Mental Illness and Violence: Are the Public at Risk? *Psychiatric Services*, 52(5), 654-659.
- Stuart, H. (2005). Why stigma matters and why it should be beaten. *World Psychiatry*, 4(51), 6-7.
- Stuart, H. (2006). Mental illness and employment discrimination. *Current Opinions in Psychiatry*, 19(5), 522-526.
- Su, D. & Li, L. (2011). Trends in the use of complementary and alternative medicine in the United States: 2002-2007. *Journal of Health Care for the Poor and Underserved*, 22, 296-310.
- Suan, L. & Tyler, J. (1990). Mental health values and preference for mental health resources of Japanese-American and Caucasian-American students. *Professional Psychology: Research and Practice*, 21(4), 291-296.

- Sue, S. (1977). Community mental health services to minority groups some optimism, some pessimism. *American Psychologist*, 32, 616-624.
- Sue, D., Sue, D.W., Sue, D. & Sue, S. (1997). *Understanding Abnormal Behaviour*. New York: Houghton Mifflin Company.
- Suite, D.H, La Bril, R. Primm, A. & Harrison-Ross, P. (2007). Beyond misdiagnosis, misunderstanding and mistrust: relevance of the historical perspective in the medical and mental health treatment of people of color. *J Natl Med Assoc*. 99(8), 879-85.
- Sumaila, A.G.F. (2013). Road crashes trends and safety management in Nigeria. *Journal of Geography and Regional Planning*, 6(3), 53-62.
- Swanson, J.W., Swartz, M.S., Essock, S.M. et al. (2002). The social-environmental context of violent behavior in persons treated for severe mental illness. *American Journal of Public Health*, 92, 1523-1531.
- Swanson, J.W., Swartz, M.S., Van Dorn, R.A. et al (2006). A national study of violent behavior in persons with schizophrenia. *Archives of General Psychiatry*, 63, 490-499.
- Tabora, B. & Flaskerud, J. (1997). Mental health beliefs, practices, and knowledge of Chinese American immigrant women. *Issues Ment Health Nurs*, 18, 173-189.
- Takeuchi, D.T., Bui, K.V. & Kim, L. (1993). The referral of minority adolescents to community mental health centers. *J Health Soc Behav*. 3(4), 153-164.
- Takeuchi, D. & Uehara, E. (1996). Mental health services to ethnic minority communities: Current research and future directions. In B.L. Levin & J. Petrilla (Eds.) *Mental health services: A public health perspective* (pp. 63–80). London: Oxford University Press.
- Tanaka, G., Inadomi, H., Kikuchi, Y. & Ohta, Y. (2006). Evaluating community attitudes to people with schizophrenia and mental disorders using a case vignette method. *Psychiatry and Clinical Neurosciences* 59(1), 96-101.
- Tanaka, G., Ogawa, T., Inadomi, H., Kikuchi, Y. & Ohta, Y. (2003). Effects of an educational program on public attitudes towards mental illness. *Psychiatry Clin Neurosci*. 57(6), 595-602.
- Tang, Y., Sevigny, R., Mao, P., Jiang, F. & Cai, Z. (2007). Help- seeking behaviors of Chinese patients with schizophrenia admitted to a psychiatric hospital. *Administration and Policy in Mental Health and Mental Health Services Research*, 34, 101-107.
- Tata, S. P. & Leong, F.T.L. (1994). Individualism-collectivism, social network orientation, and acculturation as predictors of attitudes towards seeking professional psychological help among Chinese Americans. *Journal of Counselling Psychology*, 41, 280-287.
- Taylor, S.M. & Dear, M.J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin*, 7(2), 225-240.
- Ten Have, M., De Graaf, R., Ormel, J., Vilagut, G., Kovess, V., Alonso, J. & the ESEMeD/MHEDEA 2000 Investigators (2010). Are attitudes towards mental health help-

seeking associated with service use? Results from the European Study of Epidemiology of Mental Disorders. *Soc Psychiatry Psychiatr Epidemiol*, 45(2), 153-163.

Thara, R. & Srinivasan, T.N. (2000). How stigmatising is schizophrenia in India? *Int J Soc Psychiatry*, 46, 135-141

The Mental Health Foundation of New Zealand (2003). *Respect Costs Nothing*. Wellington: The Mental Health Foundation of New Zealand.

The World Bank (2014, April 10). 'Count on Us' - Speech by World Bank Group President Jim Yong Kim at Council on Foreign Relations. Washington DC. Retrieved from <http://www.worldbank.org/en/news/speech/2014/04/01/transcript-of-world-bank-group-president-jim-yong-kims-speech-at-the-council-on-foreign-relations>.

The World Health Report 2001. Mental health: New understanding; new hope. Geneva: WHO.

Thomas, B. (1995). Caught in the frontline. *Nursing Times*, 91, 38-39.

Thomas, D.K. (2008). *West African immigrants' attitudes toward seeking psychological help*. Unpublished doctoral dissertation, Georgia State University.

Thomson, A. & Sylvester, R. (1998). Labour's new lad admits to a bit of culture on the side (interview with Frank Dobson). *Daily Telegraph*, 17, 4.

Thompson, A.H., Stuart, H., Bland, R.C. et al. (2002). Attitudes about schizophrenia from the pilot site of the WPA worldwide campaign against the stigma of schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 37(10), 475-482.

Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiologia Psichiatria Sociale*, 17(1), 14-9.

Thornicroft, G. (2013). Premature death among people with mental illness. *BMJ*, 346, f2969.

Thurman, D. & Janet, G. (1999). Trends in Hospitalization Associated with Traumatic Brain Injury, *Journal of American Medical Association*, 282, 954-957.

Tilak, J.G. (2002). Education and Poverty. *Journal of Human Development*, 3, 2.

Tobin, M. (2000). Developing mental health rehabilitation services in a culturally appropriate context: An action research project involving Arabic speaking clients. *Australian Health Review*, 23, 177-178.

Tófoli, L.F., Andrade, L.H., & Fortes, S. (2011). Somatization in Latin America: A review on the classification of somatoform disorders, functional syndromes, and medically unexplained symptoms. *Revista Brasileira De Psiquiatria*, 33, s70-s80.

Tomcsanyi, T. (2000). Mental health promotion through the dialogue of different philosophies and professions: An interdisciplinary training in mental health. *Mental Health, Religion & Culture*, 2, 143-156.

Torrey, E. F. (1994). Violent behaviour by individuals with serious mental illness. *Hospital and Community Psychiatry*, 45, 653-662.

- Torrey, F. (1995). *Surviving schizophrenia: a manual for families, consumers and providers*. New York: Harper and Row.
- Triandis, H.C. (1989). Cross-cultural studies in individualism and collectivism. In: J.J. German (Ed.) *Nebraska symposium on motivation. Cross-cultural perspectives*. Lincoln: University of Nebraska Press.
- Trzebiatowska, M. & Bruce, S. (2012). *Why Are Women More Religious Than Men?* Oxford: Oxford University Press.
- Tyler, K.M., Dillihunt, M.L., Boykin, A.W. et al. (2008). Examining cultural socialization within African American and European American households. *Cultural Diversity and Ethnic Minority Psychology, 14*, 201-204.
- Tzahr-Rubin, D. (2003). People's willingness to ask for help in time of trouble. *Haifa Forum for Social Work, 1*, 68-93.
- Uba, L. (1992). Cultural barriers to health care for Southeast Asian refugees. *Public Health Reports, 107*, 544-548.
- Ukpong, D., I. & Abasiubong, F. (2010). Stigmatising attitude towards the mentally ill: A survey in a Nigerian university teaching hospital. *South African Journal of Psychiatry, 16*, (2).
- U.S. Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General*. Washington, DC: U.S. Department of Health and Human Services.
- U.S. Department of Health and Human Services (2001). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services.
- Uher, R. (2013). The changing understanding of the genetic and environmental causes of mental illness. *Canadian Journal of Psychiatry, 58*, 67-68.
- UNESCO Institute for Statistics (2005). Gross enrolment ration by level of education. Retrieved from <http://data.uis.unesco.org/index.aspx?queryid=142&lang=en>.
- UNICEF (1988). *The Bamako Initiative Recommendations to the Executive Board for Programme co-ordination 1989 – 1993*. New York: Bamako Initiative Monitoring Unit, UNICEF.
- Uzochukwu, B.S.C. & Onwujekwe, O.E. (2004). Socio-economic differences and health seeking behaviour for the diagnosis and treatment of malaria: a case study of four local government areas operating the Bamako initiative programme in south-east Nigeria. *International Journal for Equity in Health, 3*(6).
- Vaillant, G.E. (2012). Positive mental health: Is there a cross-cultural definition? *World Psychiatry, 11*: 93–99.
- Van der Sanden, R.L., Bos, A.E., Stutterheim, S.E., Pryor, J.B. & Kok, G. (2013). Experiences of stigma by association among family members of people with mental illness. *Rehabilitation Psychology, 58*, 73-80.

- VandeCreek, L. & Burton, L. (2001). Professional Chaplancy: It's role and importance in healthcare. *The Journal of Pastoral Care*, 55(1).
- Van't Veer J.T., Kraan, H.F., Drosseart, S.H. & Modde, J.M. (2006). Determinants that shape public attitudes towards the mentally ill: a Dutch public study. *Soc Psychiatry Psychiatr Epidemiol*, 41, 310-317.
- Vaughn, L.M. & Holloway, M, (2009). West African immigrant families from Mauritania and Senegal in Cincinnati: A cultural primer on children's health. *Journal of Community Health*, 35(1), 27-35.
- Ventevogel, P. (2014). Integration of mental health into primary health care in low-income countries: avoiding medicalization. *International Review of Psychiatry*, 26(6), 669-79.
- Vera, M., Alegria, M., Freeman, D.H., Robles, R., Pescosolido, B. & Pena, M. (1998). Help seeking for mental health care among poor Puerto Ricans: Problem recognition, service use, and type of provider. *Medical Care*, 36, 1047-1056.
- Vogel, D.L., Wade, N.G. & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, 53, 325-337.
- Vogel, D.L., Wade, N.G., & Hackler, A.H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*, 54, 40-50.
- Vogel, D.L. & Wage, N.G. (2009). Stigma and help-seeking. *The Psychologist* 22, 20-23
- Vos, T., Flaxman, A.D., Naghavi, M. et al. (2012). Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990 - 2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*, 380, 2163-96.
- Wahl, O.F. (1992). Mass media images of mental illness: A review of the literature. *Journal of Community Psychology*, 20, 343 – 352.
- Wahl, O.F. & Hannan, C.R. (1989). Family views of stigma. *Schizophrenia Bulletin*, 15(1), 131-139.
- Wahl, O.F. (1995). *Media Madness: Public Images of Mental Illness*. New Brunswick, NJ: Rutgers University Press.
- Wahl, O.F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, 25, 467-478.
- Wahl, O.F. (2003). News media Portrayal of mental illness: Implications for public policies. *American Behavioural Scientist*, 46(12), 1594-1680.
- Wallach, H.S. (2004). Changes in Attitudes towards Mental Illness Following Exposure. *Community Mental Health Journal*, 40(3), 235-48.
- Walker, G.J., Courneya, K.S. & Deng, J. (2006). Ethnicity, gender, and the theory of planned behavior: the case of playing the lottery. *J Leis Res* 38(2), 224-248.

- Walters, P.B. (2001). Educational access and the state: Historical continuities and discontinuities in racial inequality in American education. *Sociology of education (extra issue)*, 35-49.
- Wang, P.S., Demler, O. & Kessler, R.C. (2002). Adequacy of treatment for serious mental illness in the United States. *American Journal of Public Health*, 92, 92-98.
- Wang, P.S., Berglund, P.A., Olfson, M. & Kessler, R.C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health Services Research*, 39(2), 393-415.
- Wang, P.S., Lane, M., Olfson, M, et al. (2005). Twelve-month use of mental health service in the United States: results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry*, 62, 629-640.
- Wang, P.S., Guilar-Gaxiola, S., Alonso, J. et al. (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *Lancet*, 370(9590), 841-850.
- Ware, J.E. Jr, Manning, W.G. Jr, Duan N, et al. (1984). Health status and the use of outpatient mental health services. *American Psychologist*, 39(10), 1090-100.
- Warner, L. (2002). *Out at Work: A Survey of the Experiences of People with Mental Health Problems within the Workplace*. London: The Mental Health Foundation.
- Watson, A.C., Corrigan, P.W. & Ottati, V. (2004). Police officer attitudes and decisions regarding people with mental illness. *Psychiatric Services*, 55, 49-53.
- Watters, E. (2010). *Crazy like us: The globalization of the American psyche*. New York: Free Press.
- Wells, J.S.G. (1998). Severe mental illness, statutory supervision and mental health nursing in the United Kingdom: meeting the challenge. *Journal of Advanced Nursing*, 27, 69-706.
- Wells, J.S., McElwee, C.N.G. & Ryan, D. (2000). "I don't want to be a psychiatric nurse": An exploration of factors inhibiting recruitment to psychiatric nursing in Ireland. *Journal of Psychiatric and Mental Health Nursing*, 7, 79-87.
- Weller L. & Grunes, S., (1988). Does contact with the mentally ill affect nurses' attitudes to mental illness? *British Journal of Medical Psychology*, 61, 277-284.
- Wellington, P. (1992). *Mental illness and the Arabic, Turkish and Vietnamese communities*. Carlton, Australia: Australian Bicentennial Multicultural Foundation.
- Westerlund, D. (1989). Pluralism and change: A comparative and historical approach to African disease etiologies. In A. Jacobson-Widding & D. Westerlund (Eds.), *Culture, experience, and pluralism: Essays on African ideas of illness and healing* (pp. 177-218). Stockholm, Sweden: Almqvist & Wiksell International.
- Whittington, R. & Higgins L. (2002). More than zero tolerance? Burnout and tolerance for patient aggression amongst mental health nurses in China and the UK. *Acta Psychiatrica Scandinavica*, 106(Suppl. 412), 37-40.

- White, R. (2013). Globalisation of Mental Illness. *The Psychologist*, 25(11).
- Wilson, C. J., Bignell, B. & Clancy, H. (2003). Building Bridges to General Practice: a controlled trial of the IDGP GPs in Schools program, first edition. *PARC Update (Special Issue: Youth Mental Health)*, 8, 19.
- Wolff, G., Pathare S., Craig T. & Leff, J. (1996). Community attitudes to mental illness. *British Journal of Psychiatry*, 168, 183-190.
- Women against Rape/Legal Action for Women (1995). *Dossier: The Crown Prosecution Service and the Crime of Rape*. London: Women against Rape.
- Wong, V.L. (1997). *Relationships among degree of acculturation, opinions about mental illness, selected socio-demographic variables and attitudes toward seeking professional psychological help among Chinese college students*. Doctoral dissertation, the University of Texas, Austin.
- Wong, D.F.K. (2007a). Crucial individuals in the help-seeking pathway of Chinese caregivers of relatives with early psychosis in Hong Kong. *Social Work*, 52, 127-135.
- Wong, D.F.K. (2007b). Uncovering sociocultural factors influencing the pathway to care of Chinese caregivers with relatives' suffering from early psychosis in Hong Kong. *Culture, Medicine and Psychiatry* 31, 51-71.
- World Health Organisation (WHO) (1978). *Declaration of Alma-Ata: Adopted at the International Conference on Primary Health Care*. Geneva: WHO.
- World Health Organization (WHO) (1995). *Bridging the Gaps*. Geneva: WHO.
- World Health Organization (2001a). *World Health Report 2001. Mental health: new understanding, new hope*. Geneva: WHO.
- World Health Organisation (WHO) (2001b). Mental Health Care in Developing Countries: A Critical Appraisal of Research Findings. *World Health Organisation Technical Report Service*, 698, 5-34.
- World Health Organization (WHO) (2002). *Traditional Medicine Strategy 2002-2005*. Geneva: WHO.
- World Health Organisation (WHO) (2008). *Mental Health Gap Action program: Scaling up care for Mental, Neurological and Substance use disorders*. Geneva: WHO.
- World Health Organization (WHO) (2010). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental health Gap Action Programme (mhGAP)*. Geneva: WHO.
- World Health Organisation (WHO) (2011). *Mental Health Atlas 2011*. Geneva: WHO.
- World Health Organization (WHO) (2014). *Injuries and Violence: the facts*. Geneva: WHO.

World Health Organisation (WHO) and International Consortium of Psychiatric Epidemiology (ICPE), (2000). Cross-national comparisons of mental disorders. *Bulletin of the World Health Organization*, 78, 413-426.

World Migration Report (2013). Geneva: International Organization for Migration.

World Psychiatric Association (WPA) (1999). *Schizophrenia: Open the Doors; The WPA Global Programme Against Stigma and Discrimination Because of Schizophrenia*. New York: World Psychiatric Association.

World Psychiatric Association (WPA) (2005). *The WPA global programme to reduce stigma and discrimination because of schizophrenia: Schizophrenia - Open the Doors Training Manual*. New York: World Psychiatric Association.

Wrigley, S., Jackson, H., Judd, F. & Komiti, A. (2005). Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town. *Australian and New Zealand Journal of Psychiatry*, 39, 514-521.

Yang, L. H. (2007). Application of mental disorder stigma theory to Chinese societies: synthesis and new directions. *Singapore Medical Journal*, 48, 977-985.

Yaşan, A. & Gürgen, F. (2004). Psikiyatri ve Fizik Tedavi Polikliniklerine başvuran hastaların geleneksel yardım arama davranışının karşılaştırılması. *Dicle Tıp Dergisi*, 31(3), 20-28.

Yates, P.J., Williams, W.H., Harris, A., Round, A. & Jenkins, R. (2006). An Epidemiological study of Head Injuries in a UK Population attending an Emergency Department. *Journal of Neurology, Neurosurgery and Psychiatry*, 77, 669-701.

Youssef, J. & Deane, F.P. (2006). Factors influencing mental health help-seeking in Arabic-speaking communities in Sydney, Australia. *Mental Health, Religion and Culture*, 9(1), 43-66.

Yusuf, A.J. (2010). Consequences of untreated severe psychiatric disorders in northern Nigeria. *African Journal of Psychiatry*, 13, 92-94

Zachrisson, H.D., Rodje, K. & Mykletun, A. (2006). Utilization of health services in relation to mental health problems in adolescents: a population based survey. *BMC Public Health*, 6, 34.

Zafar, S., Syed, R., Tehseen, S. et al (2008). Perceptions about the cause of schizophrenia and the subsequent help seeking behavior in a Pakistani population - results of a cross-sectional survey. *BMC Psychiatry*, 8, 56.

Zartalous, A. & Madianos, M.G. (2010). Mental health treatment fearfulness and help-seeking. *Issues in Mental Health Nursing*, 31(10), 662-9.

Zimbardo, P.G. & Leippe, M. (1991). *The Psychology of Attitude Change and Social Influence*. New York: McGraw-Hill.

Zimmerman, F.J. (2005). Social and economic determinants of disparities in professional help-seeking for child mental health problems: evidence from a national sample. *Health Serv Res.*, 40(5 Pt 1), 1514-33.

Appendix 1.

Content Analysis of Qualitative Data towards the Development of Quantitative Instruments to investigate Causal Beliefs, Attitudes toward People with Mental Illness, Help-seeking Pathways and Barriers to Help-seeking of Igbo People of South-eastern Nigeria.

Introduction

Mental health distresses are mostly attributable to natural, supernatural, personal or social causes. While traditional societies are associated more with supernatural and social aetiologies, Western industrialised world more commonly make natural and patient-centred explanations (Landrine and Klonoff, 1994). Beliefs of traditional cultures are however more entrenched and structured than those of the Western societies (Ballard, 1994). Helman (1990) and Weiss (1996) demonstrate that causal explanatory models influence the symptom presentation of a disorder and Compton and colleagues (2006) show that causal beliefs people hold about serious mental illnesses like schizophrenia have implication for help-seeking behaviours, recommendations for treatment and stigmatising views toward the mentally ill. Therapists agree that understanding the beliefs of clients enhances communication and most clients do best when levels of empathy are high (Tuckett and Williams, 1984). This preliminary study aims to generally sound out the views of the Igbo people regarding the causes of mental illness, their attitudes towards mental illness, their help-seeking preferences and the possible barriers that could impede their help-seeking for mental illness. The objective is to identify emerging themes/items that could be adapted in the development of a quantitative instrument for a more structured study.

Method

Instrument

An unstructured open-ended questionnaire was used to ask four major questions covering the four areas of Beliefs, Attitudes, Help-seeking preferences and Barriers to help-seeking. The

questions are; 1. What are the possible causes of mental illness? 2. What kind of associations which you have with ‘normal’ people would you not want to have with people with mental illness? 3. In what possible ways could you seek help for someone with mental illness? 4. What factors could work against your getting good hospital treatment for someone with mental illness.

Participants/Sampling Technique

Convenience sampling method was used as respondents were mostly drawn from locations close to the undergraduate assistants that helped with the administration of the questionnaires. However, a mix of schools, villages, markets, corporate business establishments in both rural and urban settings were targeted. In all, 1000 questionnaires were administered and 864 were completed and returned.

Data Analysis

Content Analysis was used to establish the frequency of occurrence of ideas expressed on causal beliefs, attitudes, help-seeking pathway preferences and perceived barriers to help-seeking.

Results

Table 1. Possible causal factors for mental illness

Causal Factors	Incidence of Occurrence	
	Frequency	Mean
Psychosocial Factors		
Personal factors		
1. Use of hard drugs /Smoking marijuana (Indian Hemp)	813	
2. Drinking alcohol in excess	318	
3. Fear/Anxiety/Worry	201	
4. Failure in life	30	
5. Over-ambitiousness/Greed/Desperation	27	
6. Faulty Upbringing/Immoral lifestyle	195	
7. Lack of willpower/Weakness/Vulnerability	60	
8. Obsession with something or somebody	30	
9. Bad temper/Anger/Rage	123	
10. Emotional Distress/Depression/sadness/regret	237	
Total Personal factors	2, 034	203.4

Social Factors		
1. Loneliness/Isolation/Incarceration (like long term jail)	75	
2. Stress/ Lack of rest	387	
3. Shock/heartbreak from misfortunes like loss of job or loss of a loved one	588	
4. Shock from good fortune like winning a lottery	51	
5. Hardship/Poverty	165	
6. Trauma from maltreatment like physical or sexual abuse	96	
7. Frustration/Disappointment/Despair	396	
8. Family troubles/ Trouble in marriage/Divorce	120	
9. Difficulties at work/school	102	
10. Too much noise	48	
Total Social Factors	2, 028	202.8
Total Psychosocial Factors	4, 062	203.1
Supernatural Factors		
Divine Punishment		
1. Divine punishment/curses (from God/the gods/the Ancestors/parents/elders/Holy men and women)	372	
2. Effect of past ancestral ritual; Sins of Forefathers	282	
3. Nemesis/Committing Abomination or Sacrilege	321	
4. Breaking of Oath/Swearing Falsely	222	
Total Divine Punishment	1, 197	299.3
Evil Forces		
1. Spiritual Attack/Witchcraft/Charm	609	
2. Evil Spirits/Demonic Possession/Marine Spirit	309	
3. Sorcery/Occultism/Ritualism	168	
4. Mismanagement/Misuse of spiritual powers	84	
Total Evil Forces	1, 170	292.5
Total Supernatural Factors	2, 367	295.9
Biological Factors		
1. Heredity	502	
2. Brain Injury/Brain Disease like Tumour	552	
3. Childbirth	36	
4. Chronic or Serious Sickness like high malaria	255	
5. Malnutrition/Hunger	69	
6. Old Age	54	
7. Wrong medication/Drug Overdose/Medical Complications	63	
8. Chronic/severe pain like constant headache/migraine	84	
9. Birth defects/improper development of the brain	30	
10. Disease/Infection (e.g. STD like syphilis)	51	
Total Biological Factors	1, 696	169.6

Table 2. Social Distance desired from people with mental illness

	Incidence of Occurrence
	Frequency Mean

1. Could not marry/date someone with mental illness	787	
2. Unwilling to be friends with someone with mental illness	438	
3. Could not do business with someone with mental illness	615	
4. Could not work together with someone with mental illness	246	
5. Unwilling to chat with someone with mental illness	345	
6. Unwilling to play/share jokes with someone with mental illness	471	
7. Could not employ someone with mental illness as domestic assistant (e.g. driver/cook/house-help/security/to run errands)	513	
8. Could not employ with someone with mental illness to take care of children	765	
9. Could not be a referee/surety for someone with mental illness	183	
10. Unwilling to share belongings with someone with mental illness	186	
11. Could not argue/Quarrel /fight with someone with mental illness	724	
12. Unwilling to sleep in the same room with someone with mental illness	483	
13. Will not confide in or share secrets with someone with mental illness	743	
14. Unwilling to seek advice from with someone with mental illness	315	
15. Would not share neighbourhood with someone with mental illness	33	
16. Could not employ someone with mental illness as security	693	
17. Could not receive injections from someone with mental illness	636	
18. Could not allow someone with mental illness to barb or make your hair	342	
19. Won't rent a house to with someone with mental illness	105	
20. Would feel ashamed to have someone with mental illness as a brother/sister	477	
21. Won't be driven in a car by someone with mental illness	447	
22. Won't have someone with mental illness as surety	237	
Total Social Distance Score	9, 784	444.7

Table 3. Help-seeking for mental illness

Spiritual/Faith Healing	Incidence of Occurrence Frequency	Mean
1. Mental illness is a spiritual problem.	392	
2. Mental illness can be cured through breaking of ancestral curses.	546	
3. If someone becomes mentally ill, he should be taken to a prayer house.	455	
4. If someone becomes mentally ill, he should be taken for deliverance or exorcism.	483	
5. Someone with mental illness should see their priest or pastor.	676	
6. A mentally ill person can get better if he keeps paying his tithes or making offerings to God.	111	
Total Spiritual/Faith Healing	2, 663	443.8
Psychiatric Hospital/GP/Counselling		

1. Mental illness is an illness like any other illness.	266	
2. I will take someone with mental illness to the nearest hospital.	658	
3. Psychiatric hospitals worsen mental illness.	77	
4. I will see a doctor if I become troubled in spirit for a long time.	497	
5. Mentally ill people should be taken to mental or psychiatric hospital.	742	
6. Mentally ill people can get better if they heed the advice of counsellors.	448	
Total Psychiatric Hospital/GP/Counselling	2, 688	448
Traditional healing		
1. Mental illness is better handled in the native or traditional	224	
2. If someone under my care becomes mentally ill, I will seek the advice of elders.	448	
3. A mentally ill person can get better if he confesses of all the evils he has done.	273	
4. People can get mental illness if they keep disregarding their culture and tradition.	238	
5. Mentally ill people should depend on their relatives	672	
6. Mental illness can come as a result of abomination committed against the land.	560	
7. A mentally ill person can get better if sacrifices are offered for his past mistakes	238	
Total Traditional Healing	2, 653	379

Table 4. Perceived Barriers to accessing formal mental healthcare

1. If a person gets mentally ill in the village, gossip will spread about that person	724	
2. I can only discuss mental illness of a relative with someone I can trust with a secret	581	
3. Mental illness makes the sufferer unproductive	385	
4. Problems like mental illness are better handled privately because of the shame it could bring	476	
5. It is safer not to get involved with issues like mental illness	497	
6. It will cost more to treat mental illness than to treat other illnesses	504	
7. People are either mad or not, there is no mid way.	511	
8. It is difficult to know where to go for mental healthcare because of the different possible causes	490	
9. We can only know that someone is mentally ill when the person starts misbehaving	637	
10. If someone under my care becomes mentally ill, I will take the person to any nearest place of treatment.	459	
11. If someone under my care becomes mentally ill, the nearest place to get good treatment is quite a distance	329	
12. I will consider the cost before deciding on where to take someone to be treated for mental illness	301	
13. Mental illness cannot be totally cured hence there is no point wasting resources	357	
14. If someone under my care becomes mentally ill right now, I am not quite sure of where to find the best treatment	392	
15. Taking mentally ill people to mental or psychiatric hospital is a way of telling the public that the person is mad.	245	
16. Considering the cost of transport, it will be better to look for cure of mental illness locally	259	
17. Places that can offer good treatment for mental illness will normally be too costly	469	
18. Mental illness is usually noticed belatedly for any effective intervention	385	
19. There can usually be long delays in places that can offer good treatment for mental illness	707	
20. If someone under my care becomes mentally ill, I will need to search to get the best treatment for him	497	
	8, 728	459.4

The pattern of perceived causes of mental illness as illustrated in Table 1 shows that the most frequently endorsed at the level of causal items was the Psychosocial factor ‘Use of hard drugs /Smoking marijuana (Indian Hemp)’ with 831 incidents of occurrence. This was followed by the Supernatural Factor ‘Spiritual Attack/Witchcraft/Charm’ with 609 incidents of occurrence while another Psychosocial Factor ‘Shock/heartbreak from misfortunes such as loss of job or

loss of a loved one' came third with 588 incidents of occurrence. The least endorsed at the level of causal items is the Psychosocial Factor 'Over-ambitiousness/Greed/Desperation' with 27 incidents of occurrence. However, at the level of Causal models, Supernatural Attributions were mostly endorsed with a mean incidence of occurrence of 295.9. This was followed by Psychosocial Attributions with mean incidence of occurrence of 203.1 while Biological Attributions came last with a mean incidence of occurrence of 169.6.

Attitudes toward mental illness as illustrated in Table 2 shows that people are most unwilling to relate with people with mental illness at such more intimate levels of involvement as marriage (787). This is followed by unwillingness to confide in or share secrets (743) and unwillingness to argue/quarrel or fight with them (724). The least expressed negative attitude was sharing neighbourhood (33), followed by unwillingness to rent a house (105) and unwillingness to be a surety (183). Table 3 shows that the greater number will seek formal mental healthcare with 448 mean incidents of occurrence. This is followed by those who will seek spiritual help 443.8 mean incidents of occurrence and those who will seek traditional help 329 mean incidents of occurrence. More than half of the respondents perceive barriers to their seeking formal mental healthcare with 459.4 mean perception of barriers.

Discussion

The predominance of Supernatural Causal Attribution corroborates earlier findings on the causal attributions of traditional societies (Odejide & Olatawaru, 1979; Mulatu, 1999; Jacobssob & Merdasa, 1991). This could be attributable largely to the deeply religious world-view of the people. Beyond demonstrating a general antipathy towards the mentally ill, the findings on attitudes also tend to reveal a pattern suggesting that the more personal, sensitive or valuable the relationship or subject matter, the less people want to involve the mentally ill. This is evidenced in the high negative scores for marriage, having a brawl (personal safety), sharing secrets (confidentiality), overseeing children (highly valued vulnerable population), and

business association (safety of investments). This invariably underscores the significant deprivation and isolation which the mentally ill experience and which could have serious adverse implication for integration and recovery. Conversely, sharing neighbourhood which appears relatively less involving compared with the other high scoring attitude markers had the lowest rating. Marriage, for instance, is highly regarded and preserved at all cost in traditional societies (Jones, 2010) to the extent that marital troubles are endured and rationalised which could explain the relatively surprising low score (120) of 'Family troubles/ Trouble in marriage/Divorce' as a social causal factor.

That a greater number will prefer psychiatric help is contrary to expectation given the predominant supernatural causal attribution that should logically inform greater preference for spiritual/faith healing. Yet, that more than half of the respondents and close to half indicated preference for spiritual and traditional healing respectively is a significant finding suggesting competing models of mental healthcare. As only a handful of studies have used theory-based models to investigate how cultural factors influence help seeking for mental health problems (Mo & Mak, 2009), it will be interesting to explore to what extent such models as TRA (TPB) and HBM could help to predict not just intentions to seek help in this population but intentions to seek particular kinds of help.

References

- Ballard, R. (1994). *Desh Pardesh: the South Asian presence in Britain*. Routledge, London.
- Compton, M.T., Esterberg, M. L., McGee, R., Kotwicki, R.J., & Olivia, J.R. (2006). Crisis intervention team training: Changes in knowledge, attitudes and stigma related to schizophrenia. *Psychiatric Services*, 57, 1199-1202.
- Helman, C. G. (1990). *Culture, health and illness: an introduction for health professionals*. London: Wright.
- Jacobsson, L. & Merdasa, F. (1991). Traditional perceptions and treatment of mental disorders in western Ethiopia before the 1974 revolution. *Acta Psychiatr Scand.*, 84(5): 475-81.

Jones, G.W. (2010). *Changing Marriage Patterns in Asia*. Singapore : Asia Research Institute, National University of Singapore.

Landrine, H., Klonoff, E. (1994). Culture diversity in causal attributions for illness: the role of the supernatural. *Journal of Behavioural Medicine* 71: 181-193.

Mo, P. K. H., & Mak, W. W. S. (2009). Help-seeking for mental health problems among Chinese. *Social Psychiatry and Psychiatric Epidemiology*.

Mulatu, M.S. (1999). Perceptions of mental and physical illnesses in north-western Ethiopia: Causes, treatments, and attitudes. *Journal of Health Psychology*, 4(4),531-549.

Odejide, A.O. & Olatawura, M.O. (1979). A survey of community attitudes to the concept and treatment of mental illness in Ibadan, Nigeria. *Nigerian Med J*, 9, 343-347.

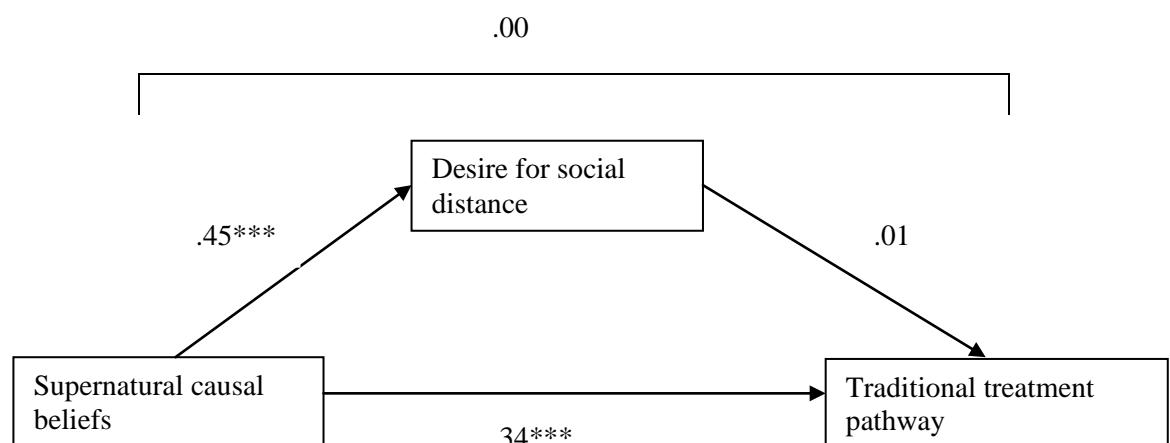
Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology*, 35, 326-334.

Tuckett, D., Williams A, (1984). Approaches to the explanation and information-giving in medical consultation: a review of empirical studies. *Social Science and Medicine* 18: 571.

Weiss, P. (1996). Explanatory Models Interview Catalogue: frame-work for the comparative study of illness experience. *Trans-cultural Psychiatry*. 34: 235-263.

Appendix 2: Tests for mediation effects of the desire for social distance and barriers to accessing mental healthcare in causal beliefs' prediction of preferred treatment pathways.

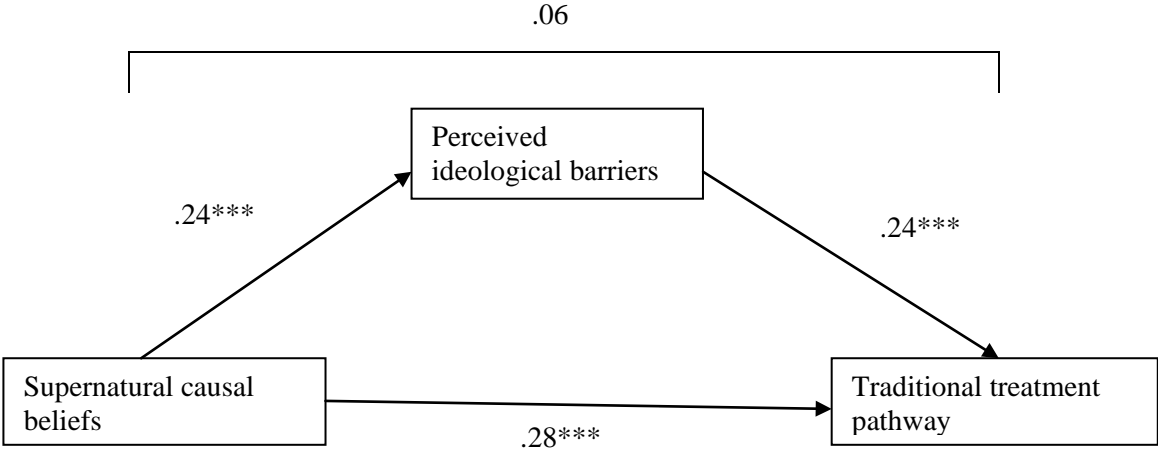
Fig. 1 Test for mediation of desire for social distance on Supernatural causal attribution's prediction of the preference for traditional treatment pathway



In the 'indigenous' model 1a (where supernatural causal belief predicted preference for the traditional treatment pathway), the standardised regression coefficient between supernatural

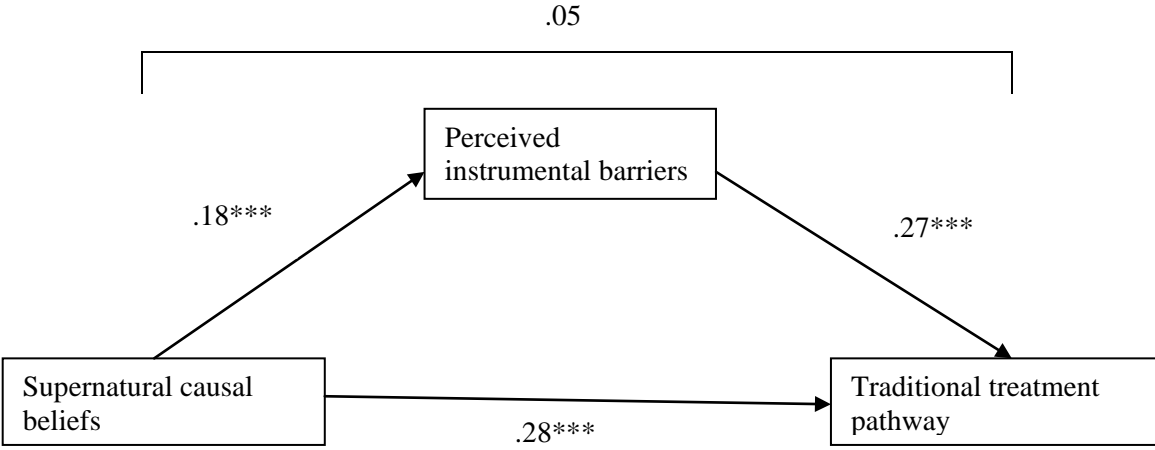
causal beliefs and desire for social distance was statistically significant $.45^{***}$. However, the standardised regression coefficient between desire for social distance and preference for the traditional treatment pathway was non-significant $.01$, ns. The bootstrapped unstandardised indirect effect was $.00$, and the 95% confidence interval ranged from $-.00$, $.01$. Thus, indirect effect was statistically non-significant.

Fig. 2 Test for mediation of perceived ideological barriers on supernatural causal attribution’s prediction of the preference for traditional treatment pathway.



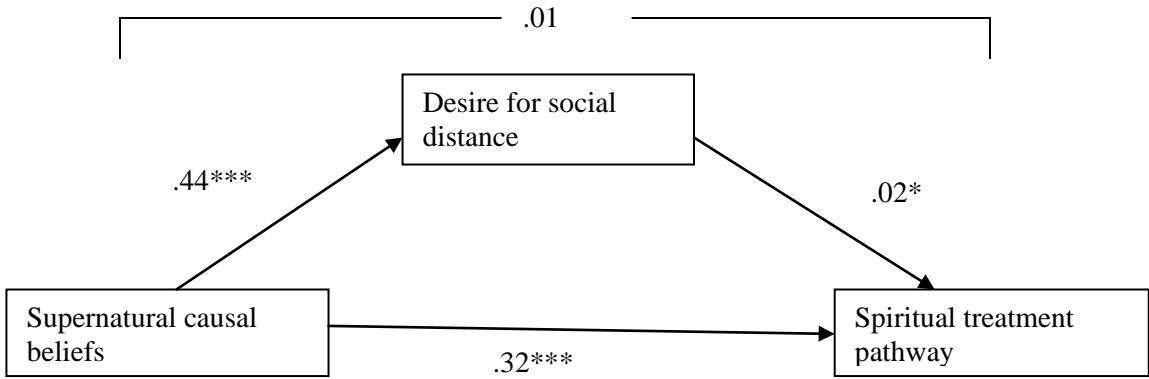
The mediation of ideological barriers was tested in the same model; the standardised regression coefficient between supernatural causal beliefs and ideological barriers was statistically significant $.24^{***}$. The standardised regression coefficient between ideological barriers and preference for the traditional treatment pathway was also significant $.24^{***}$. However, the bootstrapped unstandardised indirect effect was $.06$, and the 95% confidence interval ranged from $.04$, $.08$. Thus, indirect effect was statistically non-significant.

Fig. 3 Test for mediation of perceived instrumental barriers on supernatural causal attribution’s prediction of the preference for traditional treatment pathway.



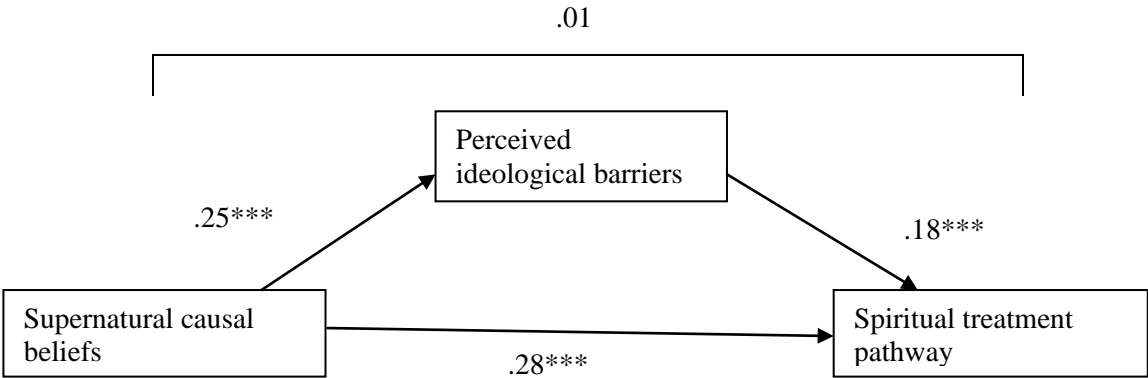
The mediation of instrumental barriers was also tested; the standardised regression coefficient between supernatural causal beliefs and instrumental barriers was statistically significant .18***. The standardised regression coefficient between instrumental barriers and preference for the traditional treatment pathway was also significant .27***. However, the bootstrapped unstandardised indirect effect was .05, and the 95% confidence interval ranged from .03, .06. Thus, indirect effect was statistically non-significant.

Fig. 4 Test for mediation of desire for social distance on supernatural causal attribution’s prediction of the preference for spiritual treatment pathway.



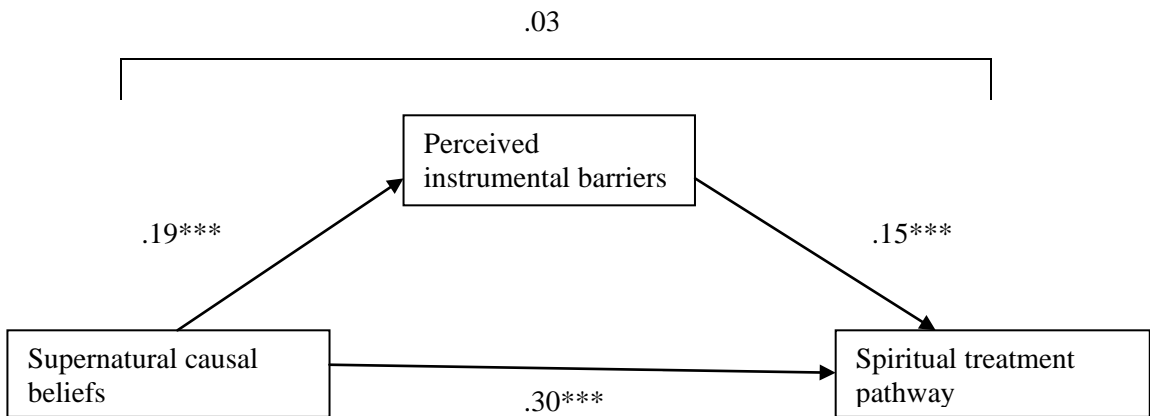
In model 1b (where Supernatural causal belief predicted Spiritual treatment pathway), the standardised regression coefficient between supernatural causal beliefs and desire for social distance was statistically significant .44***. The standardised regression coefficient between desire for social distance and preference for the spiritual treatment pathway was also significant .02*. However, the bootstrapped unstandardised indirect effect was .01, and the 95% confidence interval ranged from .00, .01. Thus, indirect effect was statistically non-significant

Fig. 5 Test for mediation of perceived ideological barriers on supernatural causal attribution’s prediction of the preference for spiritual treatment pathway.



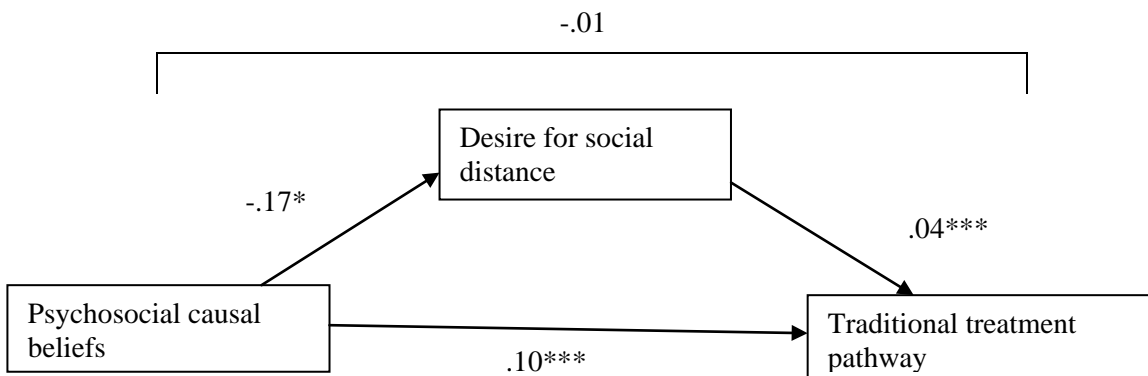
The mediation of ideological barriers was tested in the same model; the standardised regression coefficient between supernatural causal beliefs and ideological barriers was statistically significant .25***. The standardised regression coefficient between ideological barriers and preference for the spiritual treatment pathway was also significant .18***. However, the bootstrapped unstandardised indirect effect was .05, and the 95% confidence interval ranged from .03, .06. Thus, indirect effect was statistically non-significant.

Fig. 6 Test for mediation of perceived instrumental barriers on supernatural causal attribution’s prediction of the preference for spiritual treatment pathway.



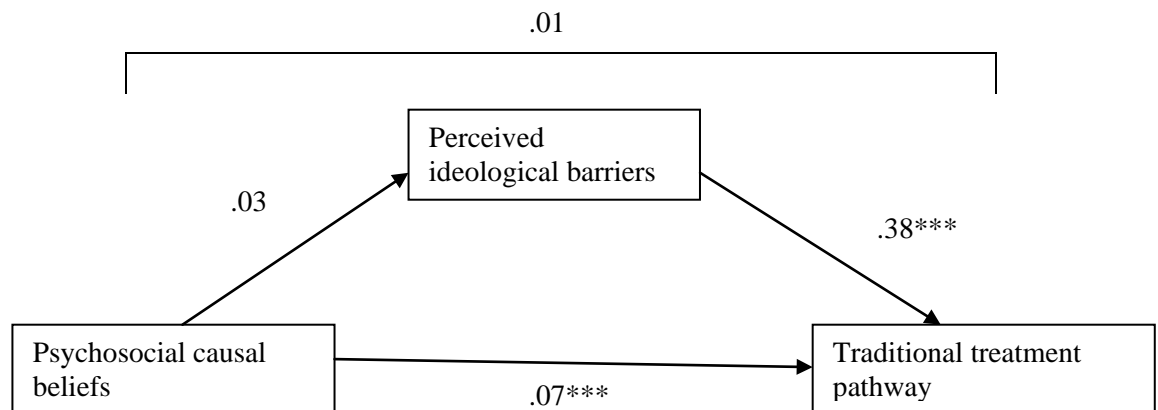
The mediation of instrumental barriers was also tested; the standardised regression coefficient between supernatural causal beliefs and instrumental barriers was statistically significant .19***. The standardised regression coefficient between instrumental barriers and preference for the spiritual treatment pathway was also significant .15***. However, the bootstrapped unstandardised indirect effect was .03, and the 95% confidence interval ranged from .02, .04. Thus, indirect effect was statistically non-significant.

Fig. 7 Test for mediation of desire for social distance on psychosocial causal attribution’s prediction of the preference for the traditional treatment pathway.



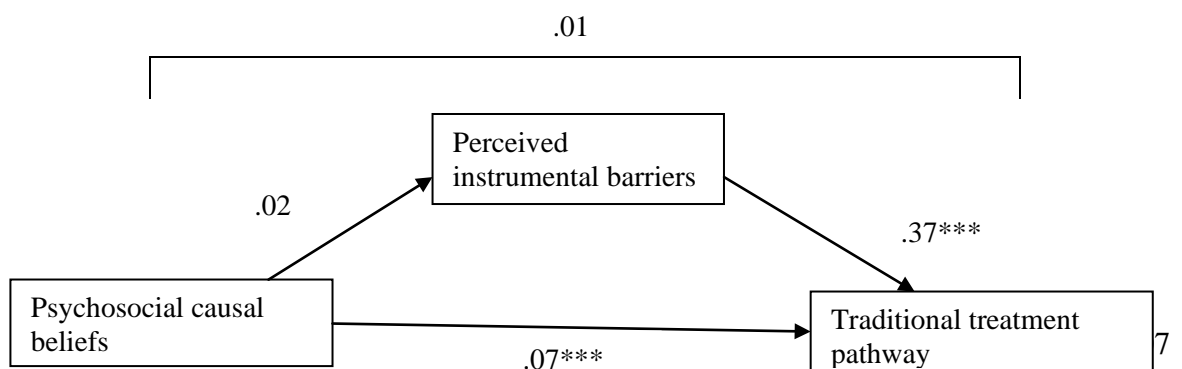
In model 3 (where psychosocial causal beliefs predicted traditional treatment pathway), the standardised regression coefficient between psychosocial causal beliefs and desire for social distance was statistically significant $-.17^*$. The standardised regression coefficient between desire for social distance and preference for the traditional treatment pathway was also significant $.04^{***}$. However, the bootstrapped unstandardised indirect effect was $-.01$, and the 95% confidence interval ranged from $-.01$, $-.002$. Thus, indirect effect was statistically non-significant.

Fig. 8 Test for mediation of perceived ideological barriers on psychosocial causal attribution's prediction of the preference for the traditional treatment pathway.



The mediation of ideological barriers was tested in the same model; the standardised regression coefficient between psychosocial causal beliefs and ideological barriers was statistically non-significant $.03$, ns. The standardised regression coefficient between ideological barriers and preference for the traditional treatment pathway was significant $.38^{***}$. The bootstrapped unstandardised indirect effect was $.01$ and the 95% confidence interval ranged from $-.00$, $.03$. Thus, indirect effect was statistically non-significant.

Fig. 9 Test for mediation of perceived instrumental barriers on psychosocial causal attribution's prediction of the preference for the traditional treatment pathway.



The mediation of instrumental barriers was also tested; the standardised regression coefficient between psychosocial causal beliefs and instrumental barriers was statistically non-significant .02, ns. However, the standardised regression coefficient between instrumental barriers and preference for the traditional treatment pathway was significant .37***. The bootstrapped unstandardised indirect effect was .01, and the 95% confidence interval ranged from -.01, .02. Thus, indirect effect was statistically non-significant.

Appendix 3: Causal Factors of Mental Illness Questionnaire (Adewuya & Makanjuola, 2008) used for study 1a.

Bio data

(1) AGE: SEX. Female:

(2) MARITAL STATUS

(a) Married (b) Not Married

(3) RELIGIOUS DENOMINATION

(a) Catholic..... (b) Protestant

(6) EDUCATION

(a) No school..... (b) Primary school.....

(c) Secondary school..... (d) Higher Education.....

Causal Explanation for Mental Illness

Which of the following do you think cause mental illness?

Factors	Strongly agree	Agree	Disagree	Strongly disagree
Social factors				
1. Stressful events in the person's life;				
2 Trouble in marriage;				
3. Financial distress/poverty;				
4. Difficulties at work/school;				
Personal factors				
1. Use of drugs / cannabis;				
2. Drinking alcohol in excess;				
3. Failure in life;				
4. Lack of willpower;				
Supernatural powers				
1. Divine punishment;				
2. God's will;				
3. Witchcraft;				
4. Sorcery;				
5. Evil spirits;				
6. Destiny;				
7. Bad luck;				

Biological Factors				
1. Heredity;				
2. Brain Injury				
3. Infections				
4. Childbirth				

Appendix 4: An adaptation of the Community Attitudes to Mental Illness scale (Taylor & Dear, 1981) used for Study 2a

Gender: Male.....Female.....**Age Range:** Below 35.....Above 35.....**Marital Status:** Married..... Not Married..... Other..... **Educational Status:** None..... Primary..... Secondary..... Undergraduate..... Graduate.....Post Graduate.....**Occupation:**.....

Religious Denomination: Catholic..... Protestant..... Pentecostal..... **Do you know someone with mental illness:** Yes..... No.....

1. Mentally ill people should be treated in their communities rather than taking them away to mental hospitals or healing homes.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
2. There is something about mentally ill people that makes it easy to differentiate them from normal people.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
3. The public is not in serious danger with mentally ill people around.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
4. Mental patients need the same kind of control as young children.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
5. A person should be taken to hospital once he shows signs of mental illness.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
6. Mental illness is an illness like any other illness.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
7. Lack of self-control is one of the main causes of mental illness
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
8. One of the best ways to handle mentally ill people is to lock them up.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
9. Anybody can become mentally ill.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
10. The mentally ill should not be treated as outcasts from society.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
11. The mentally ill are a burden on society.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

12. It is best to avoid anyone who has mental problems.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
13. Mental hospitals and healing homes seem more like prisons than places where the mentally ill can be cared for.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
14. Government should spend more money on the care and treatment of the mentally ill.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
15. The mentally ill do not deserve our sympathy.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
16. People have always made fun of the mentally ill.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree.
17. We have a responsibility to provide the best care for the mentally ill.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
18. We need to adopt a more tolerant attitude towards the mentally ill in our society.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
19. It will be waste of money should government spend more on providing mental health services.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
20. There are already enough mental health services in Nigeria.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
21. A mentally ill person has no individual rights.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
22. Women who were once patients in a mental hospital can be trusted with taking care of babies.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
23. The mentally ill should not be given any responsibility.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
24. Anyone with a history of mental illness should not serve in a public office.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
25. Mentally ill people are not as dangerous as they are presented to be.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
26. I would not want to live next door to someone who has been mentally ill.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
27. The mentally ill should live separately from the rest of the community.
A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree
28. No one has the right to prevent the mentally ill from living in their neighbourhood.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

29. Mentally ill patients should be encouraged to live normal life like other people.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

30. It would be foolish to marry someone who has suffered from mental illness even if he seems fully recovered.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

31. Having mental patients living in the community might be good for their recovery but the risks are too great.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

32. One will always be afraid if someone with mental problems lives close to their house.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

33. Mental health centres should be built outside where people live.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

34. Having mental health centres in the villages or where people live does not put the people in danger.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

35. People have good reasons to reject the building of a mental hospital in their village or close to where they live.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

36. Members of a community have nothing to fear from people coming into their area to receive mental health treatment.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

37. The best way to support the recovery of those with mental health problems is for them to be part of a normal community.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

38. As far as possible, mental health services should be provided through communities.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

39. Locating mental health centres in a village will give that village a bad name.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

40. People should accept the building of mental health centres in their communities to serve the needs of the local community.

A. Strongly agree, B. Agree, C. Disagree, D. Strongly disagree

Social Distance Scale (Ikwuka et al., 2016a) used for Exploratory Study 2b

41. Could you marry someone who has been cured of mental illness?

A. Yes, B. Possibly, C. Unlikely, D. No.

42. Would you let someone who has recovered from mental illness take care of your children for a while?

A. Yes, B. Possibly, C. Unlikely, D. No.

43. Could you be close friends with someone who has been cured of mental illness?

A. Yes, B. Possibly, C. Unlikely, D. No.

44. Could you do business with someone known to have suffered mental illness in the past?

A. Yes, B. Possibly, C. Unlikely, D. No.

45. Could you be driven in a car by someone who has recovered from mental illness?

A. Yes, B. Possibly, C. Unlikely, D. No.

46. Could you employ someone who has recovered from mental illness as your security man?

A. Yes, B. Possibly, C. Unlikely, D. No.

47. Could you employ someone who had suffered mental illness in the past as your house-help?

A. Yes, B. Possibly, C. Unlikely, D. No.

48. Could you argue with someone who has been cured of mental illness?

A. Yes, B. Possibly, C. Unlikely, D. No.

49. Would you have someone who has been cured of mental illness as your surety or witness?

A. Yes, B. Possibly, C. Unlikely, D. No.

50. Would you share belongings with someone who has been cured of mental illness?

A. Yes, B. Possibly, C. Unlikely, D. No.

51. Would you be a surety or witness for someone who has been cured of mental illness?

A. Yes, B. Possibly, C. Unlikely, D. No.

52. Would you sleep in the same room with someone who has been cured of mental illness?

A. Yes, B. Possibly, C. Unlikely, D. No.

53. Would you confide in (share secret with) a person who has been cured of mental illness?

A. Yes, B. Possibly, C. Unlikely, D. No.

54. Could you seek the advice of someone who has been cured of mental illness?

A. Yes, B. Possibly, C. Unlikely, D. No.

55. Would you rent your house to someone who has been cured of mental illness?

A. Yes, B. Possibly, C. Unlikely, D. No.

56. Would you share your neighbourhood with someone who had suffered mental illness in the past?

A. Yes, B. Possibly, C. Unlikely, D. No.

57. Would you have someone who has been cured of mental illness barb or make your hair?

A. Yes, B. Possibly, C. Unlikely, D. No.

58. Would you feel ashamed if someone in your family becomes mentally ill?

A. Yes, B. Possibly, C. Unlikely, D. No.

59. Would you have a nurse that had been cured of mental illness give you injection if you are

sick?

A. Yes, B. Possibly, C. Unlikely, D. No.

60. Would you play or share jokes with someone who has been cured of mental illness?

A. Yes, B. Possibly, C. Unlikely, D. No.

Appendix 5: Help-seeking pathways scale (Ikwuka et al., in press) used for Exploratory Study 3b

Gender: Male..... Female..... **Age Range:** Below 35..... Above 35 **Marital Status:** Married..... Not Married Other..... **Educational Status:** None..... Primary..... Secondary..... Undergraduate..... Graduate Post Graduate..... **Occupation:**..... **Religious Denomination:** Catholic..... Protestant..... Pentecostal **Do you know someone with mental illness:** Yes No.....

1. Mental illness is a spiritual problem.

A. Strongly agree
disagree

B. Agree

C. Disagree

D. Strongly

2. Mental illness can be cured through breaking of ancestral curses.

A. Strongly agree
disagree

B. Agree

C. Disagree

D. Strongly

4. If someone becomes mentally ill, he should be taken to a prayer house.

A. Strongly agree
disagree

B. Agree

C. Disagree

D. Strongly

3. If someone becomes mentally ill, he should be taken for deliverance or exorcism.

A. Strongly agree
disagree

B. Agree

C. Disagree

D. Strongly

5. If I become troubled in spirit or depressed for a long time, I may go to see my priest or pastor.

A. Strongly agree
disagree

B. Agree

C. Disagree

D. Strongly

6. A mentally ill person can get better if he keeps paying his tithes or making offerings to God.

A. Strongly agree
disagree

B. Agree

C. Disagree

D. Strongly

7. Mental illness can come as a result of abomination committed against the land.

A. Strongly agree
disagree

B. Agree

C. Disagree

D. Strongly

8. Mental illness is better handled in the native or traditional way.

A. Strongly agree
disagree

B. Agree

C. Disagree

D. Strongly

9. If someone under my care becomes mentally ill, I will seek the advice of elders.

A. Strongly agree
disagree

B. Agree

C. Disagree

D. Strongly

10. A mentally ill person can get better if he confesses of all the evils he has done.

A. Strongly agree
disagree

B. Agree

C. Disagree

D. Strongly

11. A mentally ill person can get better if sacrifices are offered for his past mistakes.

A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
12. People can get mental illness if they keep disregarding our culture and tradition.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
13. Mental illness is an illness like any other illness.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
14. If I notice signs of mental illness in someone under my care, I will take the person to the nearest hospital.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
15. Mentally ill people can get better if they follow good advice.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
16. Taking mentally ill people to mental or psychiatric hospital can worsen their case.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
17. If I become troubled in spirit or depressed for a long time, I may go and see a doctor.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
18. Mentally ill people should be taken to mental or psychiatric hospital.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
Barriers to accessing conventional mental healthcare (Ikwuka et al., 2016b) used for Exploratory Study 4b			
19. If someone under my care becomes mentally ill, the nearest place to get good treatment is quite far.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
20. If someone under my care becomes mentally ill, I will need time to search for the best treatment for him.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
21. In places that offer good treatment, there can usually be long delays before one can get attention.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
22. If someone under my care becomes mentally ill right now, I am not quite sure of where to find the best treatment.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly
23. If someone under my care becomes mentally ill, my immediate concern will be for him to get well so I will take the person to the nearest place of treatment be it hospital, prayer house or native.			
A. Strongly agree disagree	B. Agree	C. Disagree	D. Strongly

24. The cost of treatment may be considered in deciding where I will take someone to be treated for mental illness.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
25. Places that can offer good treatment for mental illness will normally be too costly.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
26. Considering the cost of transport, it will be better to look for cure of mental illness from places that are near.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
27. It will cost more to treat mental illness than to treat other illnesses.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
28. Mental illness can affect the work of the mentally ill person and even those of people caring for him that they may not have enough income to seek good treatment.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
29. It is safer not to get involved with issues like mental illness.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
30. If a person gets mentally ill in the village, gossip will spread about that person.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
31. Problems like mental illness are better handled privately because of the shame it could bring.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
32. Taking mentally ill people to mental or psychiatric hospital is a way of telling the public that the person is mad.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
33. Before discussing the mental health problem of someone close to me with anybody, it must be someone I can trust with a secret.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
34. Mental illness is not usually noticed on time; by the time it is noticed, it is usually a bit late.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
35. We can only know that someone is mentally ill when the person starts misbehaving.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
6. Mental illness cannot be totally cured.
A. Strongly agree B. Agree C. Disagree D. Strongly disagree
37. To know the best place to take someone for the treatment of mental problem may be

difficult because the problem may be spiritual e.g. an attack, medical e.g. high malaria or psychological e.g. stress
A. Strongly agree B. Agree C. Disagree D. Strongly disagree

38. People can either be mad or not mad; there are no half-ways
A. Strongly agree B. Agree C. Disagree D. Strongly disagree

Appendix 6: Combined scales for the confirmatory studies on causal beliefs, attitudes, help-seeking behaviour and barriers to help-seeking for mental illness.

Gender: Male..... Female..... **Age Range:** Below 35..... Above 35..... **Marital Status:** Married..... Not Married..... Other..... **Educational Status:** None..... Primary..... Secondary..... Undergraduate..... Graduate..... Post Graduate..... **Occupation:**..... **Religious Denomination:** Catholic..... Protestant..... Pentecostal..... Do you know someone with mental illness: Yes.....No.....

Causal Beliefs (Adewuya & Makanjuola, 2008 revised)

The following can cause mental illness;

1. Loneliness
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
2. Stressful experiences in life e.g. broken marriage
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
3. Shock e.g. from sad news
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
4. Poverty
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
5. Suffering e.g. being maltreated
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
6. Frustration e.g. not been able to get a job
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
7. Lack of self control
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
8. Anxiety e.g. fear of the unknown
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
9. Use of hard drugs / smoking Indian hemp
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
10. Drinking alcohol in excess
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
11. Failure in life
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
12. Immoral lifestyle
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
13. Lack of willpower
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree

14. Faulty upbringing
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
15. Being desperate in life
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
16. Effect of curses from God/ancestors/holy people or elders
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
17. Committing abomination/Nemesis
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
18. Effect of past ancestral rituals/sins
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
19. Breaking of oath/Swearing falsely
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
20. Bad luck
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
21. Spiritual attack/Witchcraft
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
22. Occultism/Belonging to a secret society
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
23. Spirit possession
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
24. Mishandling of spiritual powers
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
25. Heredity e.g. through family blood
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
26. Brain Injury
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
27. Childbirth
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
28. Malnutrition/Hunger
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
29. Old age
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
30. Drug reaction
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
31. Infection
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree
32. Other sicknesses like High Fever, High Malaria
A. Strongly Agree B. Agree C. Disagree D. Strongly disagree

Social Distance Scale (Ikwuka et al., 2016a)

33. Would you marry someone cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
34. Would you let someone who recovered from mental illness take care of your child for a while
A. Yes B. Possibly C. Unlikely D. No
35. Would you do business with someone cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
36. Would you be driven in a car by someone who has recovered from mental illness
A. Yes B. Possibly C. Unlikely D. No
37. Would you employ someone cured of mental illness as your security
A. Yes B. Possibly C. Unlikely D. No
38. Would you employ someone who has recovered from mental illness as your house-help
A. Yes B. Possibly C. Unlikely D. No
39. Would you have someone cured of mental illness as your surety or witness
A. Yes B. Possibly C. Unlikely D. No
40. Would you share a secret with someone cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
41. Would you allow a nurse cured of mental illness to give you injection
A. Yes B. Possibly C. Unlikely D. No
42. Would you play or crack jokes with someone cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
43. Would you live in the same yard with someone cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
44. Would you rent a house to someone cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
45. Would you seek advice of someone cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
46. Would you share belongings with someone cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
47. Would you be close friends with someone who has been cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
48. Would you have someone cured of mental illness barb or make your hair
A. Yes B. Possibly C. Unlikely D. No
49. Would you sleep in the same room with someone cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
50. Would you serve as surety or witness for someone cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
51. Would you argue with someone who has been cured of mental illness
A. Yes B. Possibly C. Unlikely D. No
52. Would you feel ashamed if someone in your family becomes mentally ill
A. Yes B. Possibly C. Unlikely D. No

53. Would you work in a mental or psychiatric hospital
A. Yes B. Possibly C. Unlikely D. No
54. Would you encourage your child to train as a psychiatrist (doctor who treats mentally ill people)
A. Yes B. Possibly C. Unlikely D. No
55. Those who treat mentally ill people equally tend to behave in a strange way
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree

Pathways to accessing mental healthcare (Ikwuka et al. in press)

56. Mentally ill people need their family and friends more than anything else.
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
57. People can get mental illness if they keep disregarding our culture and tradition
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
58. A mentally ill person can get well if he makes amend for his past mistakes
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
59. If someone under my care becomes mentally ill, I will seek the advice of elders
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
60. Mental illness is better handled in the native or traditional way
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
61. A mentally ill person can get better if he confesses all the evils he has done
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
62. A mentally ill person can get better if he keeps paying his tithes or making offerings to God
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
63. Mental illness can come as a result of abomination committed against the land
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
64. If someone is mentally ill, he should be taken to a prayer house
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
65. A person who becomes mentally ill needs deliverance
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
66. Mental illness can be cured through breaking of ancestral curses
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
67. If I become troubled in spirit for a long time, I may go and see my priest or pastor
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
68. Mental illness is a spiritual problem
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
69. Mentally ill people should be taken to mental or psychiatric hospital
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
70. If I notice signs of mental illness in someone under my care, I will take the person to the nearest hospital
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
71. Taking mentally ill people to mental or psychiatric hospital can worsen their case
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree

Barriers to accessing conventional psychiatric healthcare (Ikwuka et al., 2016b)

72. If a person gets mentally ill in the village, gossip will spread about that person
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
73. I can only discuss the mental health problem of someone close to me with someone I can trust with a secret
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
74. Mental illness makes people to be unproductive
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
75. Problems like mental illness are better handled privately because of the shame it could bring
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
76. It is safer not to get involved with issues like mental illness
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
77. It will cost more to treat mental illness than to treat other illnesses
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
78. People are either mad or not mad, there are no half ways
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
79. It is difficult to know where to go for mental healthcare because of the different possible causes.
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
80. We can only know that someone is mentally ill when the person starts misbehaving
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
81. If someone under my care becomes mentally ill, the nearest place to get good treatment is quite far
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
82. I will consider the cost before deciding on where to take someone to be treated for mental illness
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
83. Mental illness cannot be totally cured
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
84. If someone under my care becomes mentally ill right now, I am not quite sure of where to find the best treatment
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
85. Taking mentally ill people to mental or psychiatric hospital is a way of telling the public that the person is mad.
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
86. Considering the cost of transport, it will be better to look for cure of mental illness from places that are near
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
87. Places that can offer good treatment for mental illness will normally be too costly
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
88. Mental illness is not usually noticed on time; by the time it is noticed, it is usually a bit late
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
89. If someone under my care becomes mentally ill, I will need to search to get the best treatment for him
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree
90. There can usually be long delays in places that can offer good treatment for mental illness
A. Strongly Agree B. Agree C. Disagree D. Strongly Disagree

Appendix 7 Igbo translation of the study questionnaires

Causal Beliefs Scale

Ihe ndia aga aguputara gi, ha o nwere ike ibute mmadu ipu ara?

Response scale A. Ekwerem kwesie ike, B.Ekwerem, C. Ekweghim, C. Ekweghim ma ncha

1: Loneliness= enweghi onye nnodebe.

2: Stressful experience in life e.g. broken marriage=Inwetegasi umu ihe nfiaru na ndu a, okachasi/iji ma atu – esem okwu alum di na nwunye.

3: Shock e.g. From sad news= Nkuja ikekwa site n’ akuko ojoo.

4: Poverty= Ubiam

5: Suffering e.g. being maltreated= ntaram afufu/iji eze kpee ekwere, (iji ma atu) mmegbu.

6: Frustration e.g. not been able to get a job= onuma ijuputa obi kworo n’ ihi enwetaghi olu

7: Lack of self control=Madu anaghi ejidenwu onwe ya.

8: Anxiety e.g. fear of the unknown= nkolopu obi kworo n’ ihi egwu ihe madu amaghi

9: Use of hard drug/smoking of Indian hemp= inu umu ogwu ike/ise igbo.

10: Drinking alcohol in excess= inubiga nkwa ike, oke.

11: Failure in life= Agaghi n’ iru na ndu a

12: Immoral lifestyle= adighi ebi ndu n’ uzo kwesiri ekwesi.

13: Lack of willpower= enwenwughi ike.

14: Faulty upbringing= nzulite enweghi nkporogwu siri ike.

15: Being desperate in life = ichuso ihe uwa ka ana anwu anwu.

16: Effect of curses from GOD/ancestor/holy people or elders= mputara mkporom asi sitere na CHUKWU/ndi nna nna ochie/ndi nso m’obukwanu ndi okenye.

17: Committing abomination/nemesis= ime ihe aru/ihe ala n’ aso nso.

18: Effect of past ancestral rituals/sins= mputara umu aja ndi gboo chugasiri/njo ndi gboo.

19: Breaking of oath/swearing falsely= emeghi ihe onye nuru iyi ime/inu iyi aghughu/asi.

20: Bad luck= enweghi isi awele

21: Spiritual attack/Witchcraft = mmo idakwasi madu/ita madu amusu.

- 22: Occultism/belonging to a secret society= otu ojoo/madu ino n' otu nzuzo.
- 23: Spirit possession= ajo/ezi mmo ijide madu
- 24: Mishandling of spiritual power= madu amaghi eji ike nke mmo onwere wee jee ozi/luo olu.
- 25: Heredity e.g. through family blood= inweta ihe okachasi site n' obara.
- 26: Brain injury= mmeru aru nke uburu.
- 27: Childbirth= imu nwa/omumu.
- 28: Malnutrition/hunger= erighi umu ihe g' adi arum ma/aguu.
- 29: Old age= nka/okenye.
- 30: Drug reaction= aru anabataghi ogwu.
- 31: Infection= oria mbute.
- 32: Other sickness like high fever, high malaria= oria ndi ozo digasi ka oke aru-oku, oke oria iba

Social Distance Scale

Response scale: A) eee, B)E nweem ike, C)E nweghim ike, D)Mba.

- 33: Would you marry someone cured of mental illness= I g' alu onye aka gwosiri oria uburu
- 34: Would let someone who recovered from mental illness to take care of your child for a while= I ga-ekwe k' onye aka gwochapusiri n' oria uburu, ledoro gi nwa anya, nwa mgbe?
- 35: Would you do business with some one cured of mental illness= gi n' onye agwochara oria uburu, zukoo ahia?
- 36: Would you be driven in a car by someone who has recovered from mental illness= I ga=ekwe k' onye agwotaraoria uburu, buru gi n' ugbo ala?
- 37: Would you employ someone cured of mental illness as your security= I ga-ewe onye agworo oria uburu, n' olu nche?
- 38: Would employ someone cured of mental illness as your house help= I g' ewe onye agwogoro oria uburu, olu k' onye inye' aka n' ulo be gi?

- 39: Would you have someone cured of mental illness as your surety or witness= I g'ekwe k' onye agwogoro oria uburu, buru onye aka- ebe, m' obu onye mgbaputa gi ?
- 40: Would you share a secret with someone cured of mental illness = Iga akonwuru onye agwogoro oria uburu ihe nzuzo gi
- 41: Would you allow a nurse cured of metal illness to give you injection = I ga-ekwe k' onye olu nurse agwogoro oria uburu gbaa gi ntutu /ogwu?
- 42: Would you play or crack jokes with someone cured of mental illness= Gi n'onye agworo oria uburu o g' egwukonwu eguw, m' obu I g' amasanwu ya njakiri?
- 43: Would you live in the same yard with someone cured of metal illness= Gi n'onye agwogoro oria uburu aga-ebikonwu n'ime otu ngwuru ulo?
- 44: Would you rent a house to someone cured of mental illness= I g' enyenwu onye agworo oria uburu ulo ebe obibi?
- 45: Would you seek advice of someone cured of mental illness= I g'achonwu ndumodu n'aka onye agwogoro oria uburu?
- 46: Would you share belongings with someone cured of mental illness= I n'onye agwogoro oria uburu, o g'ekekonwu oke?
- 47: Would you be close friends with someone cured of mental illness= Gi n'onye agwogoro oria uburu aga abunwu ezigbote enyi?
- 48: Would you have someone cured of mental illness barb or make your hair=I g'ekwe k'onye agwobugoro oria uburu kpoo gi isi?
- 49: Would you sleep with someone cured of mental illness in the same bed=Gi n'onye agwobugoro oria uburu, ag' alarukonwu n'out akwa?
- 50: Would you serve as surety or witness to someone cured of metal illness= I ga-ekwe gbaalu onye agwobugoro oria uburu, ak' ebe?
- 51: Would you argue with someone who has been cured of mental illness= I g' ekwe ka gi n'onye riabugoro oria uburu jee baa mba?

52: Would you feel ashamed if someone in your family becomes mental ill: Ihere o g'eme gi, m'asi n'onwere onye oria uburu n'ezinulo gi?

53: Would you work in a mental or psychiatric hospital= I g' alunwu olu, n' ulogwu ebe adi agwo ndi nwere oria uburu?

54: Would you encourage your child to train as a psychiatrist (doctor who treats mentally ill people) = I g' akwado nwa gi k' oburu dibia n'agwo ndi nwere oria uburu?

55: Those who treat mentally ill people equally tend to behave in a strange way = Ndi a n'agwo ndi nwere oria uburu nwekwazii ike, in'akpa agwa n' udi diga anaa

Preferred pathways to healthcare scale

Response scale: A. Ekwerem kwesie ike, B.Ekwerem, C. Ekweghim, C. Ekweghim ma ncha

56: Mentally ill people need their family and friends more than any thing else= Ndi a n'ari oria uburu choo ka ndi ezi n'ulo, na ndi enyi ha na anokari ha oge niile.

57: People can get mental illness if they keep disregarding our culture and tradition: Ndi madu nwee ike iriaba uburu, m' oburu na ha-eleghara omenala n' odinala ndi b'anyi anya.

58: A mentally person can get well if he makes amend for his past mistakes = Onye nwere oria uburu nwee ike idikwa mma ozo, m'oburu n'ochegharia ma chigharia n'uzo ojoo ya.

59: If someone under my care becomes mentally ill, I will seek the advice of elders= Oburu n' onye etinyerem n'aka add n'oria uburu, m g'acho ndumodu site n'aka ndi okenye.

60: Mental illness is better handled in the native or traditional way= O n'akacha mma igbaso usoro nk' odinala, wee gwoo oria uburu isi

61: A mental ill person can get better if he confesses all the evil he has done: Onye nwere oria uburu nwekwaa ike idi mma ozo, m'oburu n' o kwuputesia njo ya niile.

62: A mentally ill person can get better if he keeps paying tithes or making offerings to God = Onye nwere oria uburu nwee ike idikwa mma ozo, m' oburu na o n' enye out-uzo n'uzo iri ya, ma obukwanu in' enye CHINEKE NNA onyinye di iche iche .

63: Mental illness can come as a result of abomination committed against the land =
Oria uburu nwee ike ibia , kworo n' ihi ihe ala na\` aso nso emekobara.

64: If someone is mentally ill, he should be taken to a prayer house = Oburu na madu nwee
oria uburu , si kporo ya gbajebe n'ulo ekpere.

65: A person who becomes mentally ill, needs deliverance = Onye nwetara oria uburu choro
ogwugwo nso nnaputa.

66: Mental illness can be cured through breaking of ancestral curses = enwee ike igwotali
onye nwere oria uburu, site n'igbubigasi umu uchu ogbugba ndi gboo gbara madu

67: If I become troubled in spirit for a long time, I may go and see my priest or pastor =
Oburu n' onwee ihe no esogbu mmoo m eri ogologo mgbe, enweem ike igbaje koro onye
ukochukwu

68: Mental illness is a spiritual problem = Oria uburu bukwa nsogbu si na mmoo.

69: Mentally ill people should be taken to mental or psychiatric hospital = Ekwesiri ikpoje
onye nwere oria uburu ulogwu ebe an' agwo ndi nwere oria uburu.

70: If I notice signs of mental illness in someone under my care, I will take the person
to the nearest hospital = O buru nam choputa n' onye ahanyerem n' aka iledo anya ariaba
oria uburu, agam akporo ya gbajebe n'ulogwu obula dim nso.

71: Taking mentally ill person to a mental or psychiatric hospital can worsen their case =
ikpoje onye nwere oria uburu ulogwu inye ya ogwugwo nwee ike ime ka onodu ya
kawanye njo

Barriers to accessing conventional psychiatric care scale

**Response scale A. Ekwerem kwesie ike, B.Ekwerem, C. Ekweghim, C. Ekweghim ma
ncha**

72: If a person gets mentally ill in the village, gossip will spread about that person =
Oburu na madu noro n' ime obodo ya riaba oria uburu, ejiri aha onye di otu a kuba asiri.

- 73: I can only discuss the mental health problem of someone close to me with someone I can trust with a secret = Nani onye m tukwasiri obi g' ezodonnwulum ihe nzuzom, ka nwee ike ikoro maka onye arum nwere oria uburu.
- 74: Mental illness makes people to be unproductive = Oria uburu n'ala madu n'iyi.
- 75: Problems like mental illness are better handled privately because of the shame it could bring = An' ezo ezo nwee n'agwo onye nwere oria uburu, kworo n'ih ihe o na ewetaba.
- 76: It is safer not to get involved with issues like mental illness = O kakwa mma ma madu zeere ihe obula gbasaara oria uburu.
- 77: It will cost more to treat mental illness than to treat other illnesses = Ana- emefukari ego n' igwo oria uburu karia ka esi emefube ego n'igwo oria nkiti.
- 78: People are either mad or not mad, there are no half ways = Onweghi ogologo okwu di ya, onye nwere oria uburu nwere ya, ebe onye enweghi ya enweghi.
- 79: It is difficult to know where to go for mental health care because of the different possible causes = O na esibe ike imata ebe aga akpoje onye na aria oria uburu, n'ih ihe n'otutu ihe n' ebutebe oria uburu
- 80: We can only know that someone is mentally ill when the person starts misbehaving = Anyi nwee ike imata na madu enweela oria uburu, mgbe obidoro meghebe emegheri.
- 81: If someone under my care becomes mentally ill, the nearest place to get good treatment is quite far = O buru na onye nkem enwee oria uburu, ogige ebe enwee ike ibuje ya, tere nnukwu aka.
- 82: I will consider the cost before deciding on where to take someone to be treated for mental illness = Agam eburugodi uzo mata ihe o ga ewe iji gwoo onye di otua tupu m choba imata ebe aga ebu ya je.
- 83: Mental illness cannot be totally cured = Anaghi agwochapusi oria uburu kpam kpam.

84: If someone under my care becomes mentally ill right now, I am not quite sure of where to find the best treatment = O buru n' onye nkem enwee oria uburu kitaa kita, o dochaghim anya ebem g'ebu onye di otua gbajebe iji nye ya ogwugwo kwesiri ekwesi.

85: Taking mentally ill person to a mental or psychiatric hospital is a way of telling the public that the person is mad = Ikporo onye nwere oria uburu gbajebe ulogwu, bu uzo putawagara ihe iji gosi oraneze, n' aru adichaghi onye di otu a

86: Considering the cost of transport, it will be better to look for cure of mental illness from places that are near = Maka ihi ego eg'akwu onye ugbala iji buje onye nwere oria uburu ulogwu, o kakwanu mma ichoba enyem aka n' ebe di nso .

87: Places that can offer good treatment for mental illness will normally be too costly = Ezigbo ebe adi agwo ndi nwegasiri oria uburu, digasi oke ngala onu.

88: Mental illness is not usually noticed on time, by the time it is noticed, it is usually a bit late = Anaghi amacha oge oria uburu ji amalitebe, mana onwezia k' esi choputa ya, o buru n'achoputa ya, o buru n'achoputachaaazi ya n'oge.

89: If someone under my care becomes mentally ill, I will need to search to get the best treatment for him = O buru n' onye etinyerem n'aka ilekotaa enwee oria uburu isi, ekwesiri ime nchocha miri emi, iji nweta ezi ogwugwo kacha mma, nye onye di out a.


90: There can usually be long delays in places that can offer good treatment for mental illness = Ana adiba enwebe umu ihe ndochigha azu nye n' otutu ogige maara ihe egwu n' aku , n'inye ogwugwo n' oria uburu

Appendix 8. Ethical clearance certificate from the University of Nigeria Teaching Hospital, Enugu

UNIVERSITY OF NIGERIA TEACHING HOSPITAL
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Chief Sir Dr. C. J. UDEOGU, FICS
Specialist Surgeon, Endoscopist
Chairman UNTH Management Board

Barr. S. IKE NKUME,
LL.B(Hons) BL MPA B Ed(Pol Sc.), AHAN
Ag. Director of Administration/Secretary
UNTH Management Board
UNTH/CSA/329/OL.5



Dr. C. C. AMAH, MBBS, FWACS, FICS, FIRM, FNM, FCE
Chief Medical Director

Dr. (MRS) ANNE C. NDU, MBBS, FWACP, MPH
Chairman Medical Advisory Committee
18th September, 2013.

Our Ref: _____ Date: _____

NHREC/05/01/2008B-FWA00002458-1RB00002323

ETHICAL CLEARANCE CERTIFICATE

TOPIC: PERCEPTIONS OF MENTAL ILLNESS IN SOUTH-EASTERN NIGERIA:
CAUSAL BELIEFS, ATTITUDES, HELP SEEKING PATHWAYS AND
BARRIERS TO HELP SEEKING.

BY: UGOCHUKWU IKWUKA

FOR A Ph.D THESIS OF THE UNIVERSITY OF THE DEPARTMENT OF
PSYCHOLOGY WOLVERHAMPTON, UNITED KINGDOM.

This research project on the above topic was reviewed and approved by the University of Nigeria Teaching Hospital Health Research Ethics Committee. This certificate is valid for **one year** from date of issue. Please note that the Committee Reserves the Right to monitor the Conduct of the study at any time for strict Compliance to the Protocol.

[REDACTED]
[REDACTED]
[REDACTED]
 **Prof. R.E. Umeh**
Chairman, Health Research Ethics Committee